DOCUMENT RESUME

ED 472 572 CG 032 141

AUTHOR	Saunders, B.E.; Berliner, L.; Hanson, R.F.
TITLE	Child Physical and Sexual Abuse: Guidelines for Treatment. Final Report.
SPONS AGENCY	Department of Justice, Washington, DC. Office of Justice Programs.
PUB DATE	2003-01-15
NOTE	138p.; Produced by the National Crime Victims Research and Treatment Center and the Center for Sexual Assault and Traumatic Stress.
CONTRACT	1999-VF-GX-K010
AVAILABLE FROM	National Crime Victims Research and Treatment Center, Medical University of South Carolina, 165 Cannon St., Box 250852, Charleston, SC 29425. For full text: http://www.musc.edu/cvc.
PUB TYPE	Guides - Non-Classroom (055) -- Information Analyses (070)
EDRS PRICE	EDRS Price MF01/PC06 Plus Postage.
DESCRIPTORS	*Child Abuse; Child Advocacy; *Counseling; *Counseling Techniques; *Guidelines; Mental Health Programs; *Sexual Abuse

ABSTRACT

Helping child abuse victims receive the mental health treatment they need is an important component of victim advocacy with children, and benefits both the children and the criminal justice system. As part of this work, the National Crime Victims Research and Treatment Center at the Medical University of South Carolina and the Center for Sexual Assault and Traumatic Stress at the Harborview Medical Center, University of Washington conducted a collaborative project with the Office for Victims of Crime to develop guidelines for the mental health assessment and treatment of child victims of sexual and physical abuse and their families. The primary purpose of this project was to encourage the use of mental health treatment protocols and procedures that have a sound theoretical basis, a good clinical-anecdotal literature, high acceptance among practitioners in the child abuse field, a low chance for causing harm, and empirical support for their utility with victims of abuse. These Guidelines seek to present the best available information about the mental health treatment of cases of physical and sexual abuse in a concise and consistent format that can be easily used by practitioners and other interested professionals. The Guidelines seek to cover the most common approaches, the protocols with the most empirical support, theoretically sound and promising treatments that may not have been tested empirically, and some practices that raise concern. By providing practitioners with clear and succinct information and directions for how to obtain more detailed knowledge, they will be better equipped to work with these child abuse victims and their families. (Contains 310 references.) (GCP)

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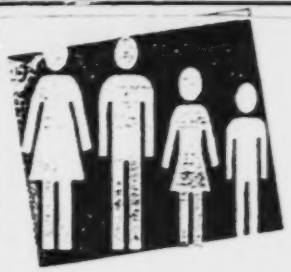

Child Physical and Sexual Abuse: Guidelines for Treatment

Final Report: january 15, 2003

Prepared by:

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This document may be downloaded electronically at:

http://www.musc.edu/cvc/

Proper citation for this document is as follows:

Saunders, B.E., Berliner, L., & Hanson, R.F. (Eds.). (2003). *Child Physical and Sexual Abuse: Guidelines for Treatment (Final Report: January 15, 2003)*. Charleston, SC: National Crime Victims Research and Treatment Center.

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INTRODUCTION

One mission of the Office for Victims of Crime of the U.S. Department of Justice is developing training and practice materials for police, prosecutors and court personnel on steps that can be taken to improve the criminal justice response to children exposed to violence. Thousands of abused children and their families become involved with the criminal justice system each year, and they often are some of the most difficult cases to manage. A critical function of victim advocacy is to insure that crime victims receive the support and intervention they need to remedy the effects of crime. Victims who receive appropriate support are better able to be cooperative with the criminal justice system, which enables the system to do its job more effectively and efficiently. Child abuse is a crime that frequently results in serious mental health problems for victims. Because it occurs behind closed doors and frequently has little physical evidence, it is a crime that requires the cooperation and often the testimony of the victim for successful prosecution. These tasks frequently are arduous for an abused child with serious, abuse-related mental health difficulties. Therefore, helping child abuse victims receive the mental health treatment they need is an important component of victim advocacy with children, and benefits both the children and the criminal justice system.

As part of this work, the National Crime Victims Research and Treatment Center at the Medical University of South Carolina and the Center for Sexual Assault and Traumatic Stress at the Harborview Medical Center, University of Washington conducted a collaborative project with the Office for Victims of Crime to develop guidelines for the mental health assessment and treatment of child victims of sexual and physical abuse and their families. Many children are treated each year for mental health problems associated with abuse. However, it is unclear how many of these children receive state-of-the-art, abuse-specific mental health treatment. A common complaint of therapists is that they often do not have ready access to the treatment outcome research literature, and they do not have time to wade through a sea of academic journals in search of the latest treatment information. Consequently, they often are concerned about whether the treatment approaches they use are the best available, and seek more efficient ways of learning about new clinical and research findings in their area.

The primary purpose of this project was to encourage the use of mental health treatment protocols and procedures that have a sound theoretical basis, a good clinical-anecdotal literature, high acceptance among practitioners in the child abuse field, a low chance for causing harm, and empirical support for their utility with victims of abuse. To accomplish this purpose, practitioners in the field need easily accessible information about available treatments, and direction concerning appropriate treatment methods for the child victims with whom they work. These Guidelines seek to present the best available information about the mental health treatment of cases of physical and sexual abuse in a concise and consistent format that can be easily used by practitioners and other interested professionals. The Guidelines are not intended to be an exhaustive and comprehensive guide to all of the treatment modalities that have been used with abused children. Rather, the Guidelines seek to cover the most common approaches, the protocols with the most empirical support, theoretically sound and promising treatments that may not have been tested empirically, and some practices that raise concern. The Guidelines can be used to identify "first choice" treatments, i.e., those that have empirical support for their efficacy; other treatments with strong clinical and theoretical support and wide acceptance within the field; novel and innovative treatments that may be used with caution; and other

interventions that lack empirical, clinical or theoretical support, should be considered experimental or even potentially dangerous, and should not be used. By providing practitioners with clear and succinct information and directions for how to obtain more detailed knowledge, they will be better equipped to work with these child abuse victims and their families.

Goals of the Project

The primary goals of this project were:

1. To develop specific criteria that can be used by clients, practitioners, agencies, payers, and other concerned parties for judging the appropriateness and efficacy of treatment procedures and protocols often used with abused children and their families.

2. To describe important characteristics of treatment procedures and protocols commonly used with abused children and their families in a concise and consistent manner that is easily accessible by professionals.

3. To classify commonly used treatment procedures and protocols according to their levels of theoretical soundness, empirical support for their therapeutic efficacy and effectiveness, clinical utility and applicability, and acceptance within the practitioner community, and potential for harm.

4. To develop a set of general guidelines for the clinical assessment and mental health treatment of abused children and their families that can be applied to cases of physical and sexual abuse.

The Guidelines are intended for use by mental health professionals, mental health treatment programs, victim/witness advocates, family/juvenile court judges, prosecutors, criminal court judges, child protective services personnel, and other practitioners who come into contact with abused children and their families. Other intended audiences include state and federal victims compensation programs, policy-makers, government mental health benefit programs (e.g., Medicaid and Medicare), private insurance companies, health maintenance organizations, related child abuse professionals, relevant professional organizations, and others concerned with the treatment of abused children. The intent of the Guidelines is to raise the standard of mental health care for abused children and their families by encouraging broader application of theoretically sound, empirically supported, and clinically accepted mental health treatment procedures. The Guidelines are designed to inform practitioners about the theoretical, empirical, and clinical characteristics of certain treatment protocols, and to encourage them to consider these characteristics carefully as they make their treatment decisions. The Guidelines will help practitioners make informed choices in their treatment selection, and help them understand the potential risks as well as benefits of specific treatment choices to their clients. The Guidelines are designed to provide direction to the child abuse field by translating current theory, research, and practice into practical recommendations for mental health treatment of child abuse victims and their families.

The Guidelines are **not** designed to be followed rigidly in every case of child abuse, or serve as a replacement for sound, case-specific clinical judgment. Nor are they intended to stifle

clinical innovation. The complexity of child abuse cases means that practitioners frequently will have to search for better ways of helping these children by using their clinical training, experience, judgment, and creativity. The Guidelines are offered as a standard, based upon the current research and clinical literatures, to inform practitioners about particular available treatments and to aid in treatment decision-making. They can be used to appraise practice in individual cases, to improve relevant policies and procedures, and to assess the array of effective services available (or not available) in communities.

Challenges for Clinical Science

The primary challenge of clinical science is to discover what treatments are effective for relieving what problems with what people in particular settings. This task applies to the treatment of child abuse victims as well as other mental health clients. A significant body of research has demonstrated that child physical and sexual abuse are significant risk factors for many mental health disorders and problems, and that substantial proportions of children who are victims of physical or sexual abuse develop serious emotional and behavioral difficulties (Beitchman, et al., 1991; Beitchman et al., 1992; Boney-McCoy & Finkelhor, 1995; Briere & Elliott, 1994; Browne & Finkelhor, 1986; Duncan et al., 1996; Felitti et al., 1998; Fergusson et al., 1996; Flisher et al., 1997; Gomes-Schwartz et al., 1990; Hanson et al., 2001; Kendall-Tackett et al., 1993; Kessler, Davis, & Kendler, 1997; Kilpatrick et al., 2000; Kilpatrick et al., in press; Pelcovitz et al., 1994; Polusny & Follette, 1995; Saunders et al., 1992; Saunders et al., 1999). Therefore, an important task of clinical science is to determine what treatments will be effective in helping these child victims recover from these abuse-related problems.

However, simply developing and testing treatment protocols with this population will not insure that victimized children will receive appropriate treatment. A second challenge is how to disseminate theoretically sound and empirically supported treatments, and train front-line practitioners in their use with child victims. Clinical science can do a wonderful job of developing and testing good treatments. Unfortunately, if the front-line practitioner is not aware of the work and is not trained to use good treatments, child victims will not benefit. Therefore, effective dissemination is necessary for the clinical process to be useful, and is the major goal of this report.

However, developing and testing good treatments and disseminating them to practitioners also is not enough. A final challenge is how to motivate clinicians in the field to actually use theoretically sound and empirically supported treatments. Mental health practitioners enjoy wide latitude in what they can do with their clients. Independent practitioners can choose how they are going to work with their clients with relatively little monitoring. Obviously, practitioners want to help their clients improve and function well. That goes without saying. Nevertheless, how clinicians choose to use certain treatment approaches and choose not to use others can be a complex process that is only partially guided by theoretical or empirical support for treatment protocols. However, getting information about the support for available and commonly used treatments into the hands of front-line practitioners is a key element in encouraging the use of sound and supported treatments. Providing such information is a critical purpose of this report.

The Clinical Science Process and Child Victims

Figure 1 illustrates an ideal view of the clinical science process with psychosocial interventions. In this process an innovative therapy protocol is developed and used cautiously in clinical settings. In a reciprocal relationship, clinical experience influences further development, which is then tested again in clinical practice. Often an anecdotal or case study clinical literature develops describing the treatment and the response of those with whom it has been used. At some point the treatment is sufficiently well-developed and determined to have potential for broader use. Efficacy studies are then conducted under carefully controlled conditions to determine if the treatment is useful with the intended treatment population. If the treatment is shown to have good empirical support when used in highly controlled and often academic settings, effectiveness studies are conducted in more "real world" treatment delivery settings using front-line practitioners. The utility of the treatment then can be tested in conditions like those in which most clients are seen. If the treatment is shown to be efficacious and effective, it is then disseminated to the field for wider use.

Ideally, this process would be applied to all treatments used with child victims of physical and sexual abuse. Treatments for problems commonly experienced by child victims would be developed and used with care and consent in clinical settings. Efficacy and effectiveness studies would be conducted, and only those treatments shown to be effective with child victims would be disseminated for use in community agencies. However, this ideal clinical process is not what typically occurs. Figure 2 illustrates the much more common situation, and the one that often has applied to the treatment of child victims as well. Treatment protocols are developed in clinical settings. However, as illustrated by arrow **A**, therapy approaches often are widely disseminated with little or no empirical testing. Dissemination is usually in the form of books written by practitioners who have developed and found a particular approach to be helpful in their work, and clinical training conducted at professional conferences and workshops. It could be argued that this arrow illustrates the historically most common approach to treatment development and dissemination in the child victim field. Arrow **B** illustrates the practice of disseminating treatment protocols after their efficacy has been tested, but prior to effectiveness studies being conducted. This course is also very common. In fact, true effectiveness studies are relatively rare. In the child victim field, there is a growing treatment outcome literature comprised of efficacy studies, and this information is gradually being disseminated as indicated by arrow **B**.

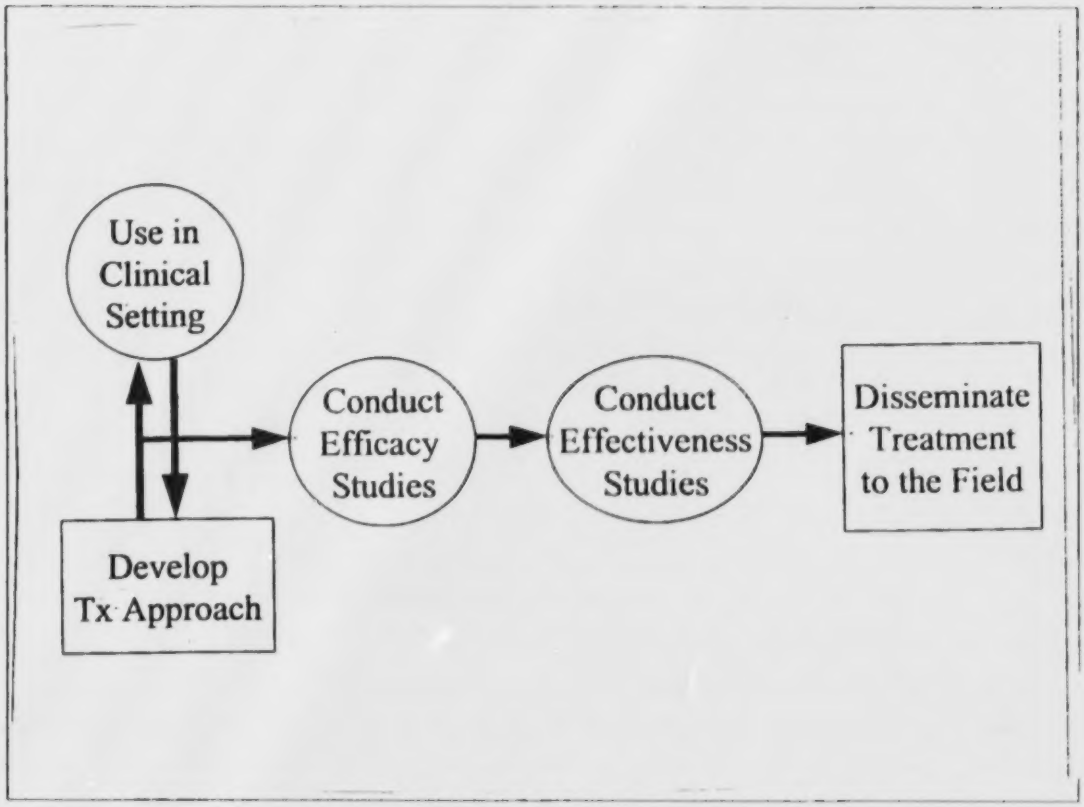

Figure 1. Ideal Clinical Science Process

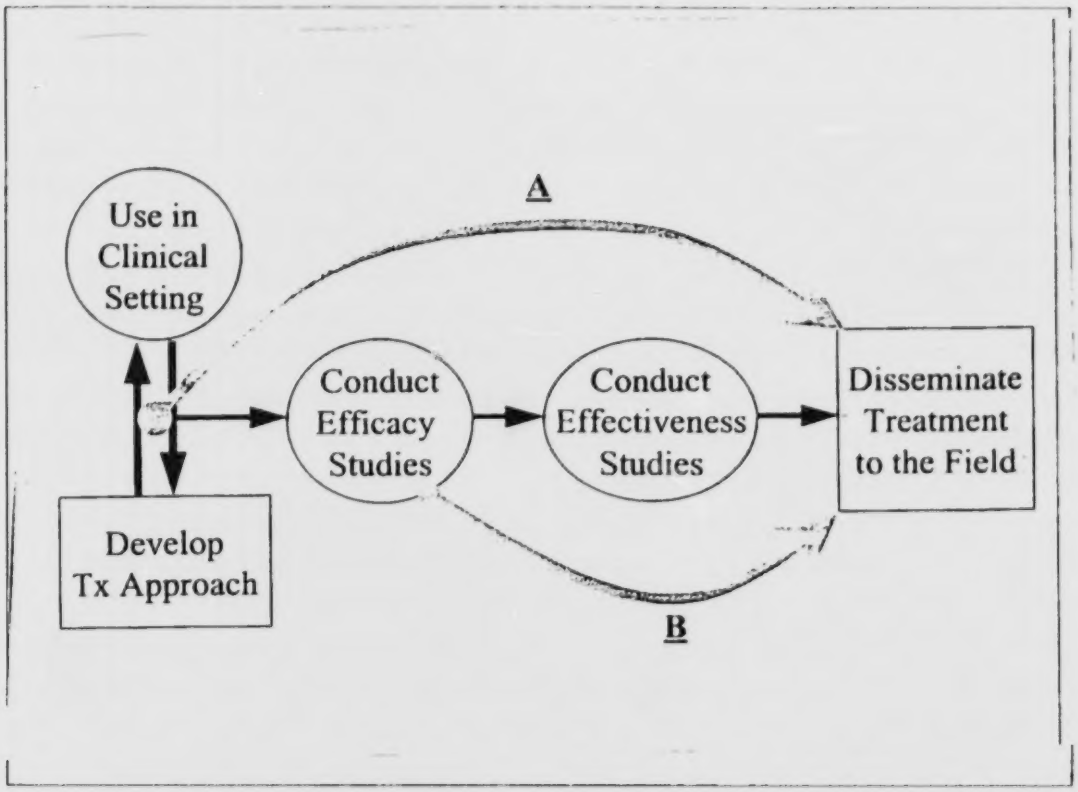

Figure 2. Common Clinical Science Process

One could argue from a strictly scientific standpoint, that the processes depicted by arrows **A** and **B** in Figure 2 are problematic. And, it is true that in a perfect world treatments would flow through the process of Figure 1 and not be disseminated and adopted by clinicians in the field until a convincing body of effectiveness research has been built. However, this progression is not what happens generally. The process depicted in Figure 1 can take many years and be very expensive. Given the relatively low resources given to testing treatments used with child victims, the cost of testing treatments, and the length of time the ideal clinical process takes, the accumulation of new empirical knowledge takes time. Given the demands of working with child victims, it is unrealistic to expect practitioners to use only treatments that have been through the process in Figure 1. There always will be a significant lag between clinical use and extensive empirical testing of psychosocial treatments. Practitioners frequently use treatments that have insufficient or even no empirical support, but appear to them to be theoretically sound and clinically useful in meeting the needs of their clients. Whether this custom is appropriate or not can be argued. However, it is a common practice.

Therefore, any attempt to develop guidelines for treatment must recognize the reality of the child victim clinical world and acknowledge that treatments that have not been through the ideal clinical process are commonly used with child victims, and that empirical support based upon effectiveness studies cannot be the sole criteria for determining acceptable treatments for practitioners in the field. Clearly, empirical support for either efficacy or effectiveness is a strong and convincing reason for using a treatment. And, when a treatment has empirical support, it should be considered superior and preferable to a treatment that does not. But, like there are gradations of empirical support, other criteria for determining an acceptable treatment must be used as well, particularly for problems for which no treatment has empirical support. Consequently, providing practitioners information about the theoretical soundness of treatments, their acceptability and use in the community, their potential for harm, as well as their empirical support was an important goal of the guideline development process.

Why Establish Guidelines Now?

Clinical and Empirical Literature. Over the past two decades, the mental health treatment of child victims of sexual and physical abuse and their abusive parents has received much attention by both the clinical and research communities. There is now a substantial body of research literature affirming the increased risk that child abuse victims have for various mental health disorders and problems, and the factors that tend to mediate these risks (Beitchman et al., 1992; Briere & Elliott, 1993; Duncan, et al., 1996; Epstein et al., 1998; Felitti et al., 1998; Fergusson et al., 1996; Kendall-Tackett, Williams, & Finkelhor, 1993; Polusny & Follette, 1995; Saunders et al., 1992; Mullen et al., 1994; Mullen et al., 1996). Relatively sophisticated theories have been developed that explain these risk mechanisms and give direction to specific approaches for clinical intervention (Briere, 1989; Cohen & Mannarino, 1996a; Deblinger, & Heflin, 1996; Friedrich, 1990; Wolfe, 1987; Wolfe, McMahon, & Peters, 1997). Great strides have been made in the development of assessment tools appropriate for use with child abuse victims and parent-offenders (Briere, 1995; Briere, 1996; Friedrich, 1998a; Hodges, 1997; Milner, 1994; Abel et al., 1998). Over the years, a large and rich clinical treatment literature has developed describing interventions that appear to be theoretically sound and have good clinical utility (e.g., Bolton & Bolton, 1987; Friedrich, 1990; Gil, 1996a; Gil, 1996b; Karp & Butler,

1996; Maddock & Larson, 1995; Sgroi, 1982). Many of these treatments have been used by practitioners for some time, and are well accepted in the field.

Most important, there now is a growing research literature testing the efficacy of mental health intervention with these populations (Berliner & Saunders, 1996; Cohen, Berliner, & March, 2000; Cohen & Mannarino, 1996b; Cohen & Mannario, 1998b; Deblinger, Lippmann, & Steer, 1996; Finkelhor & Berliner, 1995; Kolko, 1996c). Though much research remains to be done, the efficacy of at least some treatments for some problems exhibited by abused children is supported theoretically, clinically, and empirically. Still other treatment protocols and procedures have a solid theoretical basis, enjoy wide acceptance by practitioners in the field, have considerable anecdotal support for their clinical utility, but have not been subjected to empirical evaluation. Unfortunately, other treatments appear to have a relatively poor theoretical foundation and little evidence indicating they are clinically effective. Many practitioners have increasing worries that some types of theoretically questionable and empirically untested interventions actually may be harmful to at least some recipients. This concern is founded since there is evidence that some children deteriorate even after receiving treatments with empirical support (Berliner & Saunders, 1996). Most important, child deaths have been reported as the result of using some treatments (Crowler & Love, 2000; Fattah, 2002).

Because of this long history of clinical experience and the more recent empirical work, the literature concerning the clinical treatment of problems associated with child abuse has reached a critical mass. The field's clinical experience with some treatment procedures and protocols is long and the empirical research is growing. It is fair to say that mental health practitioners now have a large body of clinical and empirical knowledge to draw upon when developing treatment plans for abused children and their families. At this point, the literature is robust enough to conclude that some treatments appear to work well with these clients, others appear promising, while others are of questionable value.

It should be noted that other organizations have issued guidelines relevant to child victims of physical and sexual abuse. For example, the International Society for Traumatic Stress Studies has developed treatment guidelines for posttraumatic stress disorder (PTSD) in children (Cohen, Berliner, & March, 2000), a common outcome of child victimization. The *Journal of Clinical Psychiatry* developed a set of consensus guidelines for the treatment of PTSD, including PTSD in children (Foa, Davidson, & Frances, 1999). The American Academy of Child and Adolescent Psychiatry has developed practice parameters for the assessment and treatment of children and adolescents with PTSD (American Academy of Child and Adolescent Psychiatry, 1998). Several states have developed guidelines for treatment in child abuse cases (The Clinical Committee of the Central Maryland Sexual Abuse Treatment Task Force, 1991; CVCP Mental Health Treatment Guidelines Task Force, 1999). Therefore, other organizations also have taken note of the state of the clinical and scientific literatures and considered them sufficient to create treatment guidelines.

Responsibilities of Practitioners. Every day a great many children, parents, and families are treated for problems associated with physical and sexual abuse. These vulnerable clients are seeking help from serious problems, and practitioners know that great care should be taken in selecting assessment and treatment protocols used with them. As noted above, outpatient mental health practitioners have a great deal of independence and flexibility in

choosing what treatments to use with their clients. With this independence comes a significant level of responsibility and duty. In order to best treat their clients, practitioners have a duty to be familiar with available interventions and their supporting literature. When proven treatments for particular problems are available, responsible practitioners have a duty to be familiar with these interventions and the supporting literature, to be trained and skilled in their use, and to use them when appropriate. If they are not qualified to use the proven treatment, they have a responsibility to refer clients to practitioners who are. Clinical decisions to use alternative therapies should be made thoughtfully and be well-justified. Practitioners should refrain from using experimental, concerning, or potentially dangerous treatments. In short, practitioners have a duty to insure that their clients receive the most effective and appropriate treatment available.

Role of the Guidelines: Treatment guidelines will increase the likelihood that abused children will get the best treatment available, based upon our knowledge today. Treatment guidelines assist practitioners as they go about their work selecting which treatment procedures to use with which clients by disseminating the best knowledge to the field in a concise way and offering direction. Because much of the treatment outcome research has been conducted in recent years, some practitioners may not be aware of these findings or their implications for practice. It takes time for research findings and new clinical developments to percolate through the field to front-line practitioners and be accepted and used on a regular basis. Guidelines shorten this process by helping practitioners become aware of which treatments have strong support, which are acceptable, and which are questionable. They encourage better assessment and more appropriate treatment planning. Guidelines also can be used by judges, victim/witness advocates, caseworkers and other professionals to assess the quality of care given to the child victims for whom they are responsible.

To our knowledge, no organization or federal agency has developed guidelines specifically for the mental health treatment of child victims of sexual and physical abuse and their families. The level of knowledge and experience the field now has regarding the treatment of abused children and their families is appropriate for the development of guidelines that can be used by practitioners and other interested parties.

Use of the Guidelines

These Guidelines are intended for use by practitioners who deal with child abuse victims, supervisors, agency administrators, program developers, payers and anyone concerned with the mental health treatment of victims and families experiencing physical and sexual abuse. The Guidelines provide criteria for judging the quality of mental health treatments, a base of information describing available treatments, and a set of general guidelines for treatment based upon the best scientific literature. All of this information is intended for use by practitioners and other professionals in their treatment decision-making. The Guidelines will enable clinicians to quickly examine the theoretical basis, components, empirical support and reference materials for many available treatment protocols. Practitioners will be able to consult the Guidelines for information about what specific treatment protocols have the most empirical and clinical support as well as general principles for treatment. The Guidelines can be used as a reference source to learn more about specific treatment protocols, and where to go for materials related to the treatments. The Guidelines most obvious purpose is to guide treatment planning, treatment selection, and clinical decision making with children who have been victims of physical or

sexual abuse and their families. In addition, referral sources, victim advocates, payers, case managers and others who refer child victims for services can use the Guidelines to help assess the nature of treatment their clients are receiving. Non-clinicians, such as child protection workers, guardians *ad litem* and CASAs, lawyers representing children and parents, and judges, can use the Guidelines in making service plans that reflect the needs and problems of individual cases. Policy makers and other officials can use the Guidelines to assess their communities to see if appropriate treatment resources are in place for child victims.

The Guidelines are designed to encourage practitioners to use empirically supported treatments when they are available and appropriate for the clients they see. When such empirically supported treatments do not exist, treatments with a strong theoretical basis and wide acceptance in the clinical community are appropriate. The major goal of the Guidelines is to promote the use of treatments that have a sound theoretical basis, demonstrated clinical efficacy, wide acceptance in the field, and little danger of causing harm. The hope is that clinicians will use proven and accepted treatments as their first response to cases of child abuse, and limit their use of concerning treatments that have a significant potential for harm.

Clinical innovation and experimentation. Though the Guidelines seek to promote the use of effective and proven treatments, they were not developed to impose a rigid and inflexible standard of care on individual cases. Child abuse cases often are enormously complicated and frequently require considerable clinical innovation, judgment, and flexibility. However, the Guidelines acknowledge that much is known about treatment with these clients, and that responsible practitioners have a duty to be aware of the treatment literature and to use clinically sound, empirically supported, and accepted treatments as their first choice. The Guidelines acknowledge that appropriate, measured, and cautious clinical innovation is often necessary in complex child abuse cases. However, clinical innovation should begin from a sound foothold in the empirical and clinical literature, and be used when accepted treatments are found to be inadequate in a particular case. The Guidelines are not intended to stifle clinical innovation when it is required. However, cautious and reasoned practice innovation should not tip into uninformed experimentation. The Guidelines are not intended to inhibit new treatment development, scientific research, and experimentation. These are ongoing activities that need to be carried out and even expanded. In fact, the Guidelines repeatedly point to where new research is desperately needed. However, everyday practice is not the place for experimentation. Experimentation and research should take place with appropriate human subject protections, informed consent procedures, risk controls, and oversight by responsible organizations. The Guidelines help delineate the line between innovation and experimentation.

Cultural Issues. Cultural competence in treatment is critical to adapting mental health treatment paradigms to clients from diverse cultural, religious, and racial/ethnic groups. It is well known in the general mental health services literature that cultural, religious and racial/ethnic groups may vary in their helpseeking practices, and that mental health care in particular may be perceived quite differently by diverse groups. Different cultural groups likely have varying norms regarding many relevant issues, such as the role of the family, styles of coping with adverse life events, the cultural meaning of specific symptoms, the meaning of certain adverse life events, manners of trust and mistrust, stigma associated with mental health needs, and reliance on informal sources of help and care (U.S. Department of Health and Human Services, 2001). Language concerns, levels of acculturation, past experiences with

governmental authorities, a history of racism and discrimination, and many other issues may affect some people's willingness to seek or engage in formal mental health care. Concerns about the ethnicity or culture of the therapist, perceived clinician bias, or fears of stereotyping may affect people's willingness to engage in and remain in mental health care. Of course, the importance of cultural competence is not limited only to families from racial, ethnic, religious, or cultural minorities. Rather, understanding the cultural context of all client families is critical to treatment. Therefore, clinicians should explore with client families their cultural, religious, and ethnic identities and seek an understanding of how these factors may be relevant to the presenting problems and their care.

Intervention for problems related to child abuse must be set within this larger mental health context regarding cultural, religious, and racial/ethnic groups. Core individual and familial values and beliefs are directly relevant to the treatment of all cases of child abuse. Values and beliefs about issues pertinent to child abuse, such as sexuality, nudity, discipline practices, family boundaries, respect for elders, personal and familial privacy, family roles, acceptance of strangers, and help-seeking attitudes, are all influenced and often directly guided by a family's cultural, religious, and racial/ethnic identification. Perceptions about the helpfulness and purpose of mental services often must also be addressed. Therefore, discerning, understanding, and accommodating to the root value and belief structure of every family they treat is a fundamental skill required of therapists working with victims of child abuse and their families.

Many studies investigating questions germane to the treatment of victims of child abuse and their families, such as abuse effects, abuse-related cognitions, and mediational models, as well as treatment outcome, have included substantial proportions of participants from varied cultural and ethnic groups (Cohen & Mannarino, 1996b; Boney-McCoy & Finkelhor, 1995; Epstein et al., 1998; Saunders et al., 1992; Saunders et al, 1999) . And, potential differences between racial and ethnic identification groups are often examined (Crouch et al, 2000). However, most have focused on Caucasian and African-American participants, with some having a good representation of Hispanic/Latino populations. Other racial/ethnic and cultural groups are often under-represented and not examined. Surprisingly, the role of religious identification is rarely examined despite the importance of religion on core values and beliefs. Thus far, the limited number of treatment studies conducted have found few differences in the response to treatment between racial and ethnic groups, which is encouraging. Thus far, the data suggest that some treatments are generalizable across cultural and ethnic groups with little modification. However, much work remains to be done in this area, particularly with less prevalent cultural and ethnic groups. The potential impact of racial/ethnic identification, religious identification, and cultural background on the effects of many treatment models is simply unknown.

In an excellent review of the empirical literature on the treatment of abused and neglected children, Cohen, Deblinger, Mannarino, and de Arellano (2001) examine the influence of culture on the development of abuse-related symptoms, treatment preference, and treatment response. They suggest there is limited research on cultural considerations in treatment of abused and neglected children because treatment efficacy research in this area is relatively new. Demonstrated efficacy of a treatment approach is needed before examining the potential moderating effect of cultural, religious, and racial/ethnic factors. A limited number of research

studies have suggested that there may be racial or ethnic differences in symptom development following abuse. However, it is still unclear whether these differences are a function of cultural background or whether these differences may be due to differences in the prevalence of abuse-specific factors such as type of abuse or abuse incident characteristics (e.g., fear of injury or death, physical injury, relationship of the perpetrator to the victim, etc.) between groups. They suggest that more research is needed to understand the role of culture and ethnicity on treatment outcome, controlling for the impact of abuse incident characteristics and other contextual factors.

With regard to potential differences in treatment preference across cultural groups, data have been limited, but encouraging. Although more recent studies have included representations of different racial/ethnic groups (Berliner & Saunders, 1996; Deblinger, Lippman, & Steer, 1996), most have not reported specific analyses that would allow us to draw firm conclusions regarding cultural differences in treatment response. Those studies that have specifically analyzed for treatment response as a function of race/ethnicity have indicated few differences in treatment outcome (Cohen & Mannarino, 1996a, 1996b, 1998b; Lanktree & Briere, 1995; Kolko, 1996c). Unfortunately, these studies generally lack sufficient group sample sizes and statistical power to accurately detect how participants from varied culture or ethnic groups may differentially respond to treatment. However, the data do suggest that other factors (e.g., type of treatment provided, child's abuse-related cognitions, parental emotional distress, parental support) appear to be more important in predicting treatment outcome than race or ethnicity. In other words, it appears that there are certain abuse-specific factors related to treatment response that cut across different cultural and ethnic groups, suggesting that these may be more important than cultural identity. However, Cohen et al. (2001) point out that certain cultural groups may be more accepting of psychological services because of their inherent value systems. Therefore, one critical role of culture and ethnicity may be in affecting willingness to engage and maintain in treatment, and expectations about treatment, rather than the technical impact of the treatment itself. Given these limited findings, the role of cultural, racial, ethnic, and religious identification on treatment response in cases of child abuse remains an important area for future research, and needs to be considered in all treatment planning decisions.

Context of Treatment. The Guidelines are concerned with describing mental health interventions for the identified problems and needs of abused children and their families. However, these services are only one aspect of a community response to abused children and their families, and usually are not the first order of business. In most cases child protection and criminal justice investigations, and legal proceedings will take place before or concurrently with the delivery of mental health services. Sometimes the abuse allegations will be disputed, or parents will not agree with professionals about the nature of problems or the need for services. In many instances involvement with treatment services will be the result of plans developed by authorities and imposed on reluctant families. Practitioners who work with child abuse are expected to be sensitive to and knowledgeable about the impact of these circumstances on families who are entering treatment. Extra effort may need to be spent clarifying roles, responding to concerns about confidentiality, and engaging families in the treatment process. Treatment procedures may need to be adjusted to accommodate the context and circumstances in which they are delivered. Again, the Guidelines should be used as a basis for treatment in these situations, but should not dampen appropriate innovation.

PROCESS USED FOR DEVELOPING THE GUIDELINES

A multi-stage process was used to develop the Guidelines. First, a distinguished National Advisory Committee was assembled (see roster on page 2). This committee consisted of nationally known clinicians, researchers, educators, and administrators who have been leaders in developing, testing, teaching, and implementing treatment programs for abused children. Committee members were drawn from different professional disciplines and work settings, and represented diverse theoretical perspectives concerning treatment approaches. Second, this Committee developed the process for constructing the Guidelines, including their structure, the criteria that would be used to select and assess the various treatment protocols to be included, principles of assessment and the general principles of treatment. Third, after the procedures were established, either the developers of the selected treatments, a primary proponent of the treatment, the program director, or a person who had conducted specific research on the treatment was asked to write a brief description of the protocol following a set structure. These descriptions were then edited by Guidelines staff and returned to the original author for approval. Fourth, a classification ratings for each protocol was assigned to the treatment based upon the classification criteria presented below. These classifications were reviewed by the National Advisory Committee, further revised and finalized.

The first draft of general principles for treatment was generated by the National Advisory Committee. Based upon the results of the treatment classification process, additional comments by the National Advisory Committee, and comments from practitioners in the field, these general principles were revised several times. During this initial development period, four presentations were made at professional conferences describing the Guidelines, and comments and input from practitioners in the field were received. All portions of the Guidelines were revised in response to these comments.

An initial draft of the Guidelines was made public on June 1, 2000. This draft version was disseminated for comment to staff and grantees of the Office for Victims of Crime, members of the National Advisory Committee, and other interested professionals. The draft was posted on the web site of the National Crime Victims Research and Treatment Center (http://www.musc.edu/cvc/), and all concerned were encouraged to download and review it. Immediately after the release of this draft, the project co-directors made six presentations at national professional conferences describing the Guidelines and receiving comments from practitioners in the field. Significant feedback was also received from the field via the Internet. From June, 2000 through January, 2001, the Guidelines were downloaded over 1700 times. As a result of these dissemination activities, many comments and suggestions were received concerning the draft Guidelines. Comments were received from members of the National Advisory Committee, members of professional audiences who participated in conference presentations on the Guidelines, and professionals in the field who reviewed them. Comments came from professionals from many disciplines, from all sections of the country, and from countries outside the U.S. as well. Approximately 90-100 of the comments from the field contained substantive and important suggestions for the guidelines. A second draft of the Guidelines was released on March 30, 2001 that incorporated suggestions and comments received since the June, 2000 draft was released. A third draft was released on July 30, 2001. At that time the Guidelines had been downloaded over 2,000 times and over 300 substantive comments had been received from the field and incorporated into the draft. This draft was

delivered to the Office for Victims of Crime (OVC) of the U.S. Department of Justice. OVC staff then conducted their own internal review of the Guidelines and sent them for independent review by external experts. During this period, presentations on the Guidelines were made at eight professional conferences, and feedback received. The Guidelines have been accessed or downloaded on average 200 times per month since the July 30, 2001 release. This final version of the Guidelines (December 6, 2002) is the result of this extensive review and revision process.

Selection Criteria for Problem Areas and Treatments

The focus of the guidelines is on psychotherapeutic or psychosocial treatment modalities targeting problems with child victims, parent offenders, other family members, family relationships and the family system as a whole to address mental health and psychosocial problems specifically associated with physical and sexual abuse. Because of the extensive literature linking many problems to a history of child abuse, criteria were established to select the types of problems and subsequent interventions to be included in the Guidelines. The selection criteria recognize that while some problems are frequent sequelae in child abuse cases (e.g., posttraumatic stress, depression, sexual behavior problems), none are exclusive to child abuse and all can result from other circumstances. For example, depression, aggressive behavior, disrupted parent-child relationships, and inconsistent or coercive parent practices also occur in children and families without a history of child abuse. Fortunately there is a clinical and scientific literature documenting the utility of treatment for these conditions, and in many cases, treatments developed for these problem areas have been modified for use in child abuse situations. Therefore, the criteria do not focus only on problem areas that are most closely associated with child abuse cases. They also include problems that often occur in child abuse cases, but also may arise in other situations as well. Some problem areas that often occur in child abuse situations or may be long term effects of child abuse are not included intentionally because there is a well-developed and well-known separate treatment literature (e.g., substance abuse, depression) that is beyond the scope of these Guidelines.

As noted above, the clinical literature describing possible treatment approaches in cases of child abuse is extensive. The large portion of this literature describes procedures that have been developed by individual clinicians, used in their own work, and possibly used by some other clinicians in other settings. While many of these treatments meet some of the criteria presented below, relatively few have been tested empirically. Because the literature is so large, every treatment protocol that has been proposed for use with child abuse cases could not be included in the Guidelines. Also, many of these protocols overlap greatly and contain many of the same elements. Consequently, to include them all would mean a great deal of repetition. Therefore, in choosing which protocols to include in the Guidelines, certain preferences were used. If a treatment had been tested empirically in any scientifically reasonable fashion, it was included. If a treatment is commonly used in the field with abused children, it was included. If a treatment had been proven empirically to be useful with other populations and was being applied to abuse populations, it was included. Treatments for which manuals, books, or other writings describing their components and application were readily available were given preference. Treatments that are representative of a general class of treatments that are commonly used (e.g., parent training) or are somehow significant to the field of child abuse were included (e.g., Parents Anonymous). Attempts were made to include multiple treatments for treating victims, parents, and families. However, many books and articles available that describe

treatment protocols suggested for use with abused children and their families that were not included in the Guidelines due to space and resource limitations. The following criteria were used to select treatments and classes of treatments:

Criterion 1. There is significant research or overwhelming clinical opinion that a particular mental, emotional, or behavioral disorder or problem is clearly associated with or a result of either sexual abuse or physical abuse.

Criterion 2. A treatment protocol exists that targets the disorder or problem associated with child physical or sexual abuse.

Criterion 3. Writings describing the treatment protocol are available to clinicians in the field.

Criterion 4. The treatment protocol was developed for use by clinicians working in common treatment settings in the field, or specialists in this treatment modality available for referral.

TREATMENT PROTOCOL CLASSIFICATION SYSTEM

A primary goal of this project was to establish a clear, criteria-based system for classifying interventions and treatments according to their theoretical, clinical, and empirical support. This system can be applied not only to the treatment protocols presented in these Guidelines, but also can be used to judge the utility of other current treatments and treatments to be developed in the future. Therefore, the classification system is a tool that can be used by practitioners and others to make decisions about the appropriateness of certain treatments that are not included in these Guidelines. Further, the Guidelines reflect the state of knowledge at the time of writing. Hopefully, more research will be conducted testing the effects of existing protocols. Consequently, treatments likely will change their classifications over time as more research is completed. Therefore, the treatment classification system is a tool that can be applied to a dynamic area where information is constantly increasing.

The classification system uses criteria regarding a treatment's theoretical soundness, clinical support, acceptance within the field, potential for harm, documentation, and empirical support to assign a summary classification score. A lower score indicates a greater level of support for the treatment protocol. The summary categories are:

1 = Well-supported, efficacious treatment
2 = Supported and probably efficacious treatment
3 = Supported and acceptable treatment
4 = Promising and acceptable treatment
5 = Innovative or novel treatment
6 = Concerning treatment

Specific criteria for each classification system category are presented below:

1. Well-supported, Efficacious Treatment

1. The treatment has a sound theoretical basis in generally accepted psychological principles.

2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.

3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.

4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

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6. At least two randomized, controlled treatment outcome studies (RCT) have found the treatment protocol to be superior to an appropriate comparison treatment, or no different or better than an already established treatment when used with abused children, their parents, and/or their families.

7. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

2. Supported and Probably Efficacious Treatment

1. The treatment has a sound theoretical basis in generally accepted psychological principles.

2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.

3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.

4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

6. At least two studies utilizing some form of control without randomization (e.g., matched wait list, untreated group, placebo group) have established the treatment's efficacy over the passage of time, efficacy over placebo or found it to be comparable to or better than an already established treatment.

7. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

3. Supported and Acceptable Treatment

1. The treatment has a sound theoretical basis in generally accepted psychological principles.

2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.

3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.

4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

6. a. At least one group study (controlled or uncontrolled), or a series of single subject studies suggest the efficacy of the treatment with abused children, their parents, and/or their families, OR

   b. a treatment has demonstrated efficacy with other populations, has a sound theoretical basis for its use with abused children, their parents, and/or their families, but has not been tested or used extensively with abused populations.

7. If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

4. Promising and Acceptable Treatment

1. The treatment has a sound theoretical basis in generally accepted psychological principles.

2. A substantial clinical-anecdotal literature exists indicating the treatment's value with abused children, their parents, and/or their families.

3. The treatment is generally accepted in clinical practice as appropriate for use with abused children, their parents, and/or their families.

4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

5. Innovative or Novel Treatment

1. The treatment may have a theoretical basis that is an innovative or novel, but reasonable, application of generally accepted psychological principles.

2. A relatively small clinical literature exists to suggest the value of the treatment.

3. The treatment is not widely used or generally accepted by practitioners working with abused children.

4. There is no clinical or empirical evidence or theoretical basis suggesting that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

5. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

6. Concerning Treatment

1. The theoretical basis for the treatment is unknown, a misapplication of psychological principles, or a novel, unique, and concerning application of psychological principles.

2. Only a small and limited clinical literature exists suggesting the value of the treatment.

3. There is a reasonable theoretical, clinical, or empirical basis suggesting that compared to its likely benefits, the treatment constitutes a risk of harm to those receiving it.

4. The treatment has a manual or other writings that specifies the components and administration characteristics of the treatment that allows for implementation.

ASSESSMENT IN CASES OF CHILD ABUSE

A basic principle of all clinical practice is that assessment should precede the initiation of interventions. Based upon the results of the assessment, a treatment plan should be developed that is tailored to the problems and needs of individual family members and the family as a whole. The likelihood of successful outcome is enhanced substantially when effective interventions are matched correctly to specific problems discerned through appropriate assessment. A mismatch of treatment to problem is at best a waste of scarce resources, and can prolong suffering, lead to deterioration in the client, or even endanger children. Most important, when proper assessment is not conducted or the treatment approach fails to target the problems identified, children do not receive the treatment they need for the problems they have. Assessment is also an integral component of the ongoing treatment process. Periodic evaluation of previously identified problems, emergent problems, and treatment progress are necessary parts of therapy. Ongoing assessment results provide feedback about whether the target problems have resolved or if a different intensity or type of therapy is indicated. All of these generally accepted principles of assessment apply to cases of child abuse.

Special Issues in Child Abuse Cases

Child maltreatment cases have special characteristics that must be addressed in assessment. The most important of these is determining how safe the living environment is for the child victim. Since many abused children continue to live with the caregivers or siblings who have hurt them or in families where domestic violence occurs, this focus on safety is a priority. Therefore, understanding the level of risk for harm in the child's environment and subsequent safety planning are the first steps in assessment in abuse cases. Evaluation of risk identifies what structural and contextual interventions may be necessary (e.g., separation, professional supervision, chaperone program), as well as initial treatment targets (e.g., parental substance abuse, behavior management skills, anger control). It also forms the basis for clinical assessment and intervention. For example, even if children exhibit posttraumatic stress symptoms, it is difficult to proceed in therapy while they are still in dangerous (and fear-producing) situations. Treatment of fear and anxiety symptoms likely will be fruitless or even harmful because it would be appropriate for a child to continue to be afraid and vigilant in such a situation. If treatment continues, children may be desensitized to real danger cues, placing them at greater risk in the future. Therefore, evaluation of environmental and contextual risk and safety is a unique and critical part of the assessment process in abuse cases.

Another special consideration in abuse cases is the stance of caregivers with regard to the charges of maltreatment. In many cases parents enter or bring their children to treatment because child protection authorities have intervened and recommended or required their attendance. In some cases they may be seeking treatment only because they are court-ordered to do so. Parents may dispute the abuse allegations or minimize the harmful impact on their children. Assessment of parental perceptions and stage of readiness to change is a central ingredient of developing a meaningful treatment plan. Successful therapy outcome for maltreated children who live with their parents and for parental deficits requires some degree of cooperation with a treatment process. Belief and support by a non-offending parent has been shown to contribute to the treatment of child distress in sexual abuse situations (Cohen &

Mannarino, 1998a). Identifying the nature and extent of the obstacles to parental engagement provides direction for the focus of treatment especially in the early stages of intervention.

Assessment of Children

Maltreated children often have emotional or behavioral problems as a result of their abuse experiences or their abusive family environment. As noted above, substantial research has documented the types of problems and mental health disorders frequently experienced by abused children. These common problems include fear, anxiety, posttraumatic stress symptoms, depression, sexual difficulties, poor self-esteem, stigmatization, difficulty with trust, cognitive distortions, difficulty with affective processing, aggression, disruptive behavior, peer socialization deficits, and other problems. Consequently, each of these problems that are commonly exhibited by abused children should be assessed carefully using the best assessment tools available.

The nature and severity of disturbance can vary substantially from child to child. In some cases, abused children will not exhibit any clinically significant distress at initial assessment. A review of clinical studies of sexually abused children found that up to 40% of children, depending on the outcome, were apparently asymptomatic (Kendall-Tackett, Williams, & Finkelhor, 1993). Other abused children will be terribly disturbed and suffer from major mental health disorders, and still others will have moderate problems. The absence of detectable problems may be the result of active symptom suppression by the child, avoidance coping strategies, or simple resilience. At least some of these asymptomatic children will have a delayed onset of disturbance (Gomes-Schwartz et al., 1990; Kendall-Tackett et al., 1993; Mannarino et al., 1991). That is, they will develop abuse-related problems months or even years after the abuse has stopped. Therefore, assessment should consider risk factors for the development of future problems, as well as reported difficulties.

The first task of assessment involves determining the direct effects of the abusive events, i.e., those problems that clearly stem squarely from the abusive behaviors experienced by the child and likely have no other significant etiology. For example, probably the most abuse-specific outcome of physical or sexual abuse experiences is posttraumatic stress symptoms. About half of sexually abused and one third of physically abused children will meet diagnostic criteria for posttraumatic stress disorder (PTSD), and more will have at least some posttraumatic stress symptoms (McLeer et al., 1998; McCloskey & Walker, 2000). Therefore, PTSD symptoms should be targets for evaluation. Screening for posttrauma symptoms requires that the experience be explicitly discussed so that re-experiencing and avoidance symptoms can be assessed. Numbing and hyperarousal symptoms may not be identified without specific inquiry. Consequently, assessing for PTSD requires directly approaching the abuse experiences in the evaluation process. This axiom is true for other abuse-related fears and anxieties as well.

Assessment of abused children should be abuse-informed, but not exclusively abuse-focused. That is, the assessment should evaluate not only the potential problems that are the direct effects of abuse, but also pre-existing and concomitant difficulties as well. The abuse informed component of assessment should address cognitions as well as symptoms. Abuse-specific (e.g., self-blame, guilt) and abuse-related (e.g., stigmatization, shame) attributions are associated with increased distress and may lead to conditions such as depression, low self

esteem, and impaired socialization that are common in abused children. For the most part, practitioners must rely on clinical interviews to determine whether children have maladaptive beliefs about their experiences.

Some behavior problems are common among maltreated children, although they can have other etiologies. For example, sexual behavior problems are noted in about one-third of sexually abused children (Friedrich, 1993). Anger control problems and aggression are frequently observed in physically abused children (Kolko, 2002). These disruptive behaviors may be the result of intense negative emotions associated with maltreatment or learned responses to the experiences. However, they can also arise from causes other than abuse. Comprehensive assessment will include targets that are commonly exhibited by abused children, even though they may have other causes.

In addition to the abuse focus of assessment, abused children also should be evaluated for the presence of emotional and behavioral problems that may or may not be the direct result of the abuse experiences, but none the less impair functioning. Diagnostic interviews and standardized behavior checklists can be useful in assessing for these problems. At minimum, evaluators should screen for the presence of depression, anxiety disorders, and disruptive behavior disorders.

It goes without saying that assessment of children should be developmentally informed. One consequence of abuse and reactions to abuse is that the developmental trajectory of the child victim is derailed. What may begin as an abuse-specific symptom (e.g., decreased concentration due to re-experiencing symptoms) can lead to problems of functioning (e.g., poor school performance, poor occupational achievement), which may produce negative socialization patterns (e.g., association with delinquent peers), that can create risk for serious pathology (e.g., substance abuse, delinquency). Or the pathway to disrupted development may be quite direct (e.g., aggression or early sexualization) and will interfere with normal peer social relationships. One assessment approach is to determine systematically the level of functional impairment or the degree to which children are having difficulties in role functioning at home, school, in the community and in their behavior with others.

Assessment of Parent/Caregiver-Child and Other Familial Relationships

Parent/caregiver-child relationship quality is a critical part of any abuse case and should be a target of assessment (Lipovsky et al., 1993). Assessment and treatment must pay attention not only to the offender-victim portion of the relationship, but also the parent-child aspect (Saunders & Meinig, 2000), which may be more important to the child. Common areas of assessment are similar to targets of assessment in any family case and include parent-child communication, affectional connection, styles of conflict management, discipline practices, and levels of trust. A special point of assessment is insecure parent-child attachment. Insecure attachment often is associated with abuse experiences either as a precursor to abuse or a result. This problem tends to significantly disrupt parent-child relationships, and is presumed to set the stage for lifelong problems in relating to others as children acquire working models for interpersonal relationships within their families. Assessment of attachment style in the clinical setting is generally based on the reports of children and parents about the quality of the relationship, as well as observations of parent/caregiver-child interactions. There are a number

of ways to make crude classifications. For example, one way to think about attachment style is children's valuations of self and others, with secure children evincing consistent positive views of self and others, while insecure children tend to have either negative perceptions of themselves, others or both. Parental responses to children can also be evaluated in terms of the degree to which they are responsive versus inconsistent, distant, or a source of danger. Classifying children into one of the insecure attachment categories is less important clinically than assessing the nature and quality of parent-child relationships, and identifying problematic relationships that should be a treatment focus.

While the importance of evaluating and addressing children's capacity to form and maintain successful relationships is not disputed, there are controversies about the determination of attachment problems in children. It is not uncommon for some abused children to be labeled "attachment disordered" or given the diagnosis of Reactive Attachment Disorder, despite the fact that the dimensions of the diagnostic category have not been fully clarified (Hanson & Spratt, 2000). Anecdotally, there is reason to be concerned that in some cases, application of the label or diagnosis may lead to very negative or even hopeless perceptions of these children. This is of special concern for children in foster care who may have options for permanency or adoption foreclosed because of the associated stigma. Assessment for attachment problems should clearly specify the basis for drawing conclusions and the nature of the disturbance in order to form a basis for treatment interventions.

Parental approaches to discipline should be an important focus evaluation in all cases, and should not be limited to cases referred for physical abuse. Inconsistent, ineffective, or coercive discipline practices create negative interactional patterns and child behavior problems. They may also lead to physical abuse in an escalating cycle of child misbehavior, parental frustration and loss of control that leads to abuse. The practices of nonoffending as well as abusive parents should be assessed. Nonoffending parents may be contending with children's abuse related-symptoms or reactions to the family disruption at a time when they feel overwhelmed. Many cases of less serious physical abuse are the result of discipline gone too far. Exploration of how parents handle children's misbehavior will identify areas for inclusion in the treatment plan.

Family system characteristics, sibling relationships, extended family relationships, and couple/marital and sexual relationships between parents are also important areas of assessment and possible intervention (Nash et al., 1993; Dadds et al., 1991; Saunders et al., 1995; Smith & Saunders, 1995). Several studies have found that abusive families tend to be more socially isolated, have more rigid patterns of interaction, value familial control over individual behavior, are more likely to have authoritarian interpersonal styles, and have significant levels of marital and sexual relationship dissatisfaction. These family system and marital/couple factors often constitute a context for abuse to emerge and be maintained. Therefore, marital and family relationships and system characteristics are appropriate targets of clinical assessment and intervention.

Assessment of Parents

Screening for parental disorders or family characteristics that may impact children's adjustment and parental capacity to cooperate with treatment is an essential element of assessment. Parental depression and substance abuse are specific disorders that, when present, will substantially undermine parents' abilities to provide assistance to their children in the aftermath of abuse and are associated with re-referral to child protection authorities. Fortunately, especially in the case of depression, effective treatments are available. When necessary, therapists treating abused children should refer parents to appropriate intervention programs or be able to provide the services as part of a comprehensive treatment plan. Explaining the ways that these conditions interfere with helping children recover may be a helpful strategy to overcome parental resistance to a focus on their problems since most non-offending parents and some offending parents do have concern for their children's welfare.

Level of parental distress regarding abuse of the child in sexual abuse cases has been shown to be an important determinant of children's emotional and behavioral status (Cohen & Mannarino, 1998a; Hanson et al., 1992). Therefore, the impact on the parent of learning about and coping with results of child maltreatment is important to address. In addition to children's emotional needs, there may be system interventions including investigations, legal proceedings, child placement, and disruption in living situations and arrangements that are a source of stress for the parents. Problem solving and stress management strategies may be indicated to alleviate distress that interferes with parental capacity to respond to their children and participate in other interventions.

Level of belief and support about the abuse experience has been found to correlate with children's adjustment in sexual abuse cases and are typically a focus of intervention (Cohen & Mannarino, 1998a; Morris et al., 1996). Whether these factors are important for physically abused children has not been the specific subject of investigation. Treatments for physically abused children have not generally required that parents acknowledge the abusiveness of the behavior. In fact, some writers have recommended against an emphasis on labeling the behavior. This is probably because in most cases of physical abuse in treatment contexts, the children are living in the home with the abusive parent and both are participating in joint treatments. However, some assessment of parental views about what happened, and the wrongful or harmful nature of the behavior is likely to be relevant to treatment planning.

Offending parents or siblings, especially in the case of sexual abuse may suffer from a variety of deficits that require specific interventions. In the case of physical abuse, these may be assessed in terms of attitudes toward the use of violence and the repertoire of behavioral skills parents possess for responding to child misbehavior. In sexual abuse cases, degree of responsibility taken for the abuse, attitudes about the harmful consequences, skills deficits, and empathy are frequent targets for treatment. In addition, certain pathologies, sexual deviance and antisocial or psychopathic characteristics are predictive of risk to reoffend. Standards for assessment methods for sexual offenders have been promulgated by the Association for the Treatment of Sexual Abusers (2001) and may involve the use of psychophysiological technologies such as the polygraph and penile plethysmography. Sexual offender treatment is generally considered an area of specialty practice that requires highly specialized knowledge and training.

Use of Standardized Measures

Standardized assessment instruments can be very useful tools in the assessment of abused children and their families. As the term implies, they provide a standardized and structured approach to measuring problems commonly experienced by abused children, and can help provide a more precise assessment of target problems. They also can be administered over time to assess treatment progress and aid in clinical decision-making. Several instruments have been developed specifically for measuring abuse-related problems and have been tested with abused children. They are designed to evaluate problems frequently experienced by these children and to be used specifically in cases of abuse. In addition, many general mental health measures that are used with all sorts of child populations have been used successfully with abused children. All of these instruments can be clinically valuable when assessing abused children and their families. Standardized measures should be considered as part of any comprehensive clinical assessment process. Examples of instruments that have been used successfully in child abuse cases and can be recommended for use include:

Child Abuse Potential Inventory (Milner, 1986)
Child and Adolescent Functional Assessment Scale (Hodges, 1997)
Child Behavior Checklist (Achenbach, 1991)
Child Sexual Behavior Inventory (Friedrich, 1998a)
Children's Impact of Traumatic Events Scale (Wolfe & Gentile, 1991)
Child's Attitude towards Mother Scale (Hudson, 1982)
Child's Attitude towards Father Scale (Hudson, 1982)
Fear Survey Schedule for Children–Revised (Ollendick, 1978)
Index of Self Esteem (Hudson, 1982)
Kovacs' Children's Depression Inventory (Kovacs, 1992)
Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1985)
Symptom Checklist-90-Revised (Derogatis, 1983)
Trauma Symptom Checklist for Children (Briere, 1996)
Trauma Symptom Inventory (Briere, 1995)

Obviously, this is not an exhaustive or comprehensive list of measures that can be useful in child abuse cases. Rather, they are examples of measures that have been used successfully with abused children and their families. Appropriate standardized measures should be selected according to the problems to be assessed in any assessment.

Treatment Planning

A treatment plan should be based directly on the results of the assessment. It should coincide with problems and needs that have been identified for the children, their parents, and the family. Feedback and discussion of the results with family members are important ingredients of the assessment process. They can also aid in generating cooperation with the treatment plan and positive expectations for treatment. Clinicians should be able to explain and support diagnoses and recommendations in every day language and by using examples. In this way assessment becomes a first step in engagement in therapy. It also is important to be able to highlight areas of competent functioning and strengths. These are the building blocks for growth and successful therapies.

The acceptability of a treatment plan may rest in part on the degree to which children and families perceive that there is respect for their particular circumstances, background, and values. As previously mentioned, cultural and religious factors can be especially relevant. For example, while there is a clinical wisdom that openness and discussion about sexual abuse can help ameliorate trauma symptoms, in some cultures a recommendation that a child participate in a group or talk openly in the family or to friends about sensitive matters may conflict with cultural expectations and place a child in worse circumstances. Family, religious, or cultural values that are supportive of corporal punishment may conflict with treatment approaches that eschew these methods. Families may prefer to seek treatment with providers or in settings where they believe there will be greater understanding or appreciation of their cultural identity and values and where they are more comfortable. Clinicians should inquire about these issues during the assessment process and to the extent that families can be accommodated without compromising essential treatment considerations, treatment plans may be more likely to be carried out.

The practicality of treatment plans is also important. It is not helpful to present families with a long list of treatment recommendations that may overwhelm them and seem never ending. Plans that call for services that are unavailable, require many sessions per week, or are beyond the financial means of the family are not useful because it is unlikely they will be followed. Many families where child maltreatment has occurred are poor or struggling in the first place, and their financial circumstances may have been worsened by abuse-related systems interventions. Maltreating families often lack organizational skills, tend to be socially isolated, and may not have much experience with using resources outside the family. Triage, constructing a plan with a reasonable number of recommended interventions, identification of specific settings that offer the needed services, flexibility in scheduling appointments, and advocacy to secure concrete assistance with transportation and child care may be necessary to implement a treatment plan.

Summary of Assessment

In summary, assessment is the cornerstone of the treatment process. Without accurate, comprehensive, and sophisticated assessment, followed by reasonable treatment planning, interventions are likely to be misguided and ultimately ineffective. Assessment in abuse cases should focus on, but not be limited to, problems known to be common among abused children. The special issues surrounding abuse cases such as risk assessment, safety planning, and the complicated familial and parent-child relationship issues that exist should be a part of the assessment process. Assessment should result in an accurate portrayal of the functioning of the abused child and their family within their cultural context. Treatment planning should target these problems in a realistic way and apply the best treatments available to the revealed problems.

TREATMENT PROTOCOLS FOR CASES OF SEXUAL AND PHYSICAL ABUSE

The 24 treatment approaches described in the following reference section were selected based on the criteria described above. They target abuse consequences in children, problems of parents or parent/child relationships significantly associated with maltreatment, or abusive behaviors of parents. These approaches do not constitute an exhaustive or comprehensive list of treatments that may be necessary or useful in child abuse cases. For example, pharmacological interventions are not included although they may be helpful adjunctive treatments for children or parents. Many parents will have substance abuse disorders or major depressive disorder, both of which are risk factors for reabuse. There are well-established interventions for depression and substance abuse that are not covered in these guidelines. In many cases children or parents will suffer from comorbid psychiatric conditions (e.g., ADHD, conduct disorder, oppositional defiant disorder, personality disorders) or live in environmental circumstances (e.g., poverty, inadequate housing) that may need to be a focus of intervention but are not specific to child abuse.

The selected interventions are designed to reflect the array of abuse specific interventions typically used or considered in cases of child maltreatment. In some cases particular program models were chosen because they represent exemplary programs of the type and have been the subject of evaluation or research (e.g., therapeutic childcare and intensive family intervention). The various parenting interventions are presented because parenting classes or interventions are routinely recommended or ordered in child maltreatment cases. Although it is likely that most of the usual community-based parenting programs are not as intensive or empirically grounded as the programs described in this document, treatments focused on parenting practices are a central component of the treatment response to abuse situations. Most of the remainder of the interventions were specifically developed to treat abuse-related conditions.

Each treatment protocol description consists of the following sections:

Brief Description
Theory and Rationale
Treatment Components
Treatment Manuals or Protocol Descriptions
Treatment Outcome Study References
Common Length of Treatment
Classification Rating

Treatments are divided into three sections:

I. Child-Focused Interventions
II. Parent, Parent-Child, and Family Focused Interventions
III. Offender Focused Interventions

This reference section is provided for the purpose of assisting clinicians in selecting treatment components that can be matched to concerns that are identified during the assessment process. In many cases children and families will benefit by more than one protocol, including treatments that are not included here. In a particular case, different practitioners may deliver

different treatments to provide a comprehensive treatment approach to families. However, it is assumed that the abuse-related problems and the needs of the abused children will be the clinical priority and the primary focus of treatment. Whenever possible it is desirable that non-offending parents participate in children's therapy. Some treatment approaches include components designed to strengthen the parent-child relationship. In other situations, it may be incorporated into an abuse-focused treatment program as a separate component.

Treatment that is specifically directed at the parent's abusive behavior may or may not be relevant to treatment planning for the abused children depending on the clinical presentation and family structural context. In cases of less serious physical abuse, children will often remain living with the abusing parent, and treatment that includes a focus on the parent-child relationship and parental disciplinary practices is essential. In other cases, children will be separated from abusing or non-protective parents. Treatment for the parents will be required if the child is to be returned to the home. However, the parents may not be available or cooperative with treatment recommendations. In these cases, children should still be assessed and treated for abuse consequences, regardless of whether the parents are involved.

Child Focused Interventions

Cognitive-Behavioral and Dynamic Play Therapy for Children with Sexual Behavior Problems and Their Caregivers

Prepared by Barbara Bonner, Ph.D.

Brief Description:

These two group treatment approaches were designed for children ages 6 to 12 and their caregivers who exhibit sexual behavior beyond normal child sexuality and that causes problems in their functioning. One approach is based on the principles of cognitive behavioral therapy, and the other is based on dynamic play therapy. They are designed to reduce the occurrence of inappropriate and/or aggressive sexual behavior in children.

Theory and Rationale:

Children who have been maltreated sometimes develop sexual behavior problems. Two theoretically different approaches to group treatment have been developed and tested. The two approaches, cognitive-behavioral therapy and dynamic play therapy, are frequently used for behavior problems in children, have evidence for effectiveness, and can be used in a wide range of mental health settings. The principles of cognitive-behavior therapy and its use with children have been well described in the literature (e.g., Meyers & Craighead, 1984). The behavioral component is straightforwardly concerned with human behavior and broadly based on the principles of learning theory. The cognitive aspect emphasizes the complex cognitions involved in information processing in human beings, such as beliefs, attributions, decision-making processes, and their influence on behavior. The cognitive-behavioral approach used in this program relies on behavior modification principles for group management and incorporates strategies directed at cognitive rules, decision making, impulse control, and education. It is highly structured and uses a teaching-learning model.

The rationale for the use of dynamic play therapy is that children with sexual behavior problems may be experiencing intense negative emotions stemming from sexual, physical and/or emotional abuse, neglect, and/or other trauma (Friedrich, 1990; Friedrich & Luecke, 1988; Smith & Israel, 1987). Inappropriate processing and expression of these feelings may result in sexual behavior. Play therapy assumes that play is the child's natural medium for expression and is a vehicle for emotional processing and behavior change. The spontaneous interactions combined with the controlled conditions in a play therapy setting provide a means for achieving goals that therapists have identified as critical in working with children with sexual behavior problems (Gil & Johnson,1993). These goals include helping children gain insight into their own behavior; increasing children's ability to observe and appreciate other people's feelings, needs, and rights; helping children understand their needs and values, and to develop their own goals and internal resources; increasing children's ability to meet their needs in socially appropriate ways; and increasing children's connectedness to positive others and building internal strengths that support future growth. The dynamic play therapy approach used in this program incorporates aspects of client-centered and psychodynamic play therapies. The client-centered aspects help instill self-efficacy and self-worth in the participants. The psychodynamic aspects help ensure productive interactions between group members and increased self-understanding or insight. Both approaches have been found equally effective in reducing children's sexual behavior problems at

the two-year follow-up (Bonner, Walker, & Berliner, 2000). The treatments consist of twelve once weekly sessions.

Treatment Components:

Cognitive-Behavioral Therapy

- Acknowledgment of breaking sexual behavior rule(s).
- Learning and applying Sexual Behavior Rules for children.
- Impulse control through learning and applying the Turtle Technique (a stop and think before acting strategy).
- Receiving age-appropriate sex education.
- Cognitive reframing to prevent reabuse of or by the child.
- Weekly assessment of acquisition of information.
- Positive reinforcement for appropriate behavior and participation in group exercises.
- Caregiver participation in collateral group treatment that includes education regarding age-appropriate sexual behavior in children, assisting children with applying the Sexual Behavior Rules and Turtle Technique, child behavior management techniques, and rules for supervision.

Dynamic Play Therapy

- Reflection to increase child's self understanding (insight).
- Acceptance to convey positive regard for the child and improve the child's self-esteem.
- Interpretation to assist children in identifying and expressing feelings.
- Facilitating group interaction to improve peer relationships.
- Caregiver participation in collateral group treatment that uses acceptance, reflection, and interpretation to process problems presented by the caregivers; encourages interaction among the parents; and uses the group process/interaction as the modality of change.

Duration of Treatment: 12 sessions

Treatment Manual or Protocol Descriptions:

Bonner, B., Walker, C.E., & Berliner, L. (1999). *Treatment manual for cognitive-behavioral group therapy for children with sexual behavior problems.* National Clearinghouse on Child Abuse and Neglect: Washington, DC. 1-800-394-3366.

Bonner, B., Walker, C.E., & Berliner, L. (1999). *Treatment manual for cognitive-behavioral group treatment for parents/caregivers of children with sexual behavior problems.* National Clearinghouse on Child Abuse and Neglect: Washington, DC. 1-800-394-3366.

Bonner, B., Walker, C.E., & Berliner, L. (1999). *Treatment manual for dynamic group play therapy for children with sexual behavior problems and their parents/caregivers.* National Clearinghouse on Child Abuse and Neglect: Washington, DC. 1-800-394-3366.

Treatment Outcome Study References:

Bonner, B., Walker, C.E., & Berliner, L. (2000). *Final report. Children with sexual behavior problems: Assessment and treatment.* Grant No. 90-CA-1469. National Clearinghouse on Child Abuse and Neglect: Washington, DC. 1-800-394-3366.

Classification Rating: 3

Cognitive Processing Therapy (CPT)

Prepared by Patricia Resick, Ph.D. and Gretchen Clum Ph.D.

Brief Description:

Cognitive Processing Therapy (CPT) is a brief, structured, cognitive-behavioral treatment designed to treat posttraumatic stress disorder (PTSD) and associated features such as depression. CPT is a therapy consisting of exposure to the traumatic memory, training in cognitive restructuring, and modules on topics that are most likely to be affected by rape and other interpersonal trauma.

Theory and Rationale:

Exposure-based (Foa & Kozak, 1986) and cognitive therapies (McCann & Perlman, 1990) are often used to treat trauma victims. CPT combines both approaches with the cognitive components tailored for rape victims, although treatment strategies can be modified for other traumatic experiences. CPT has been developed to help trauma victims (1) understand how thoughts and emotions are interconnected, (2) accept and integrate the traumatic experience as an event that actually occurred and cannot be ignored or discarded, (3) experience fully the range of emotions attached to the event, (4) analyze and confront maladaptive beliefs, and (5) explore how prior experiences and beliefs both affected reactions and were affected by the trauma.

The goals of CPT are twofold. One goal is exposure to the traumatic memory. Although exposure is important because it helps to activate the client's fear-structure, it does not provide direct corrective information regarding misattributions or maladaptive beliefs (Resick & Schnicke, 1993). Therefore, a cognitive component is added to address these issues. The cognitive component is based on the theory that traumatic experiences are often problematic because the new information often does not fit into existing schemas. Without a way to understand and categorize the experience, the strong emotions associated with traumatic experiences are left unprocessed. In addition, when individuals encounter new information that is inconsistent with preexisting beliefs or schemas, one of two things can occur: assimilation or accommodation. Assimilation involves distortion of new information so that such information is consistent with schemas, while accommodation involves altering schemas because of the new discrepant information. Over-accommodation occurs when schemas are changed at an extreme level as a result of the traumatic experience. Assimilation and over-accommodation are problematic because they often lead to self-blame, guilt, manufactured emotions such as embarrassment or shame, or dysfunctional cognitions. One goal of CPT is to help clients move from using these strategies to using accommodation while processing cognitions related to the traumatic experience. Outcome studies support CPT as a treatment for PTSD and PTSD-related depression. In one clinical outcome study CPT in a group format was superior to wait list control for both PTSD and depression at post-treatment and at a 6-month follow-up (Resick & Schnicke, 1992). CPT produces symptomatic relief within 12 treatment sessions.

Treatment Components:

- Information and education regarding symptoms of PTSD, information processing theory.
- Explore meaning of event, client writes impact statement.

- Identification of thoughts and feelings, Antecedents-Behavior-Consequences sheets.
- Discussion of self-blame and labeling of event.
- Exposure – client writes description (account) of event, reads aloud in session, process affect.
- Identification of stuck points (conflicting beliefs or strong negative beliefs that create unpleasant emotions or unhealthy behavior) .
- Challenging Questions, Faulty Thinking Patterns, and Challenging Beliefs Worksheet (incorporates A-B-C sheets, challenging questions and faulty thinking patterns).
- Five individual modules covering issues of safety, trust, power/control, esteem and intimacy related to oneself and others.
- Explore meaning of event, client writes second impact statement at end of therapy.

Duration of Treatment: 12-16 sessions

Treatment Manuals or Protocol Descriptions:

Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, CA: Sage Publications.

Calhoun, K. S., & Resick, P. A. (1993). Treatment of PTSD in rape victims. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders*, (pp. 48-98). New York: Guilford Press.

Treatment Outcome Study References:

Ellis, L. F., Black, L. D., & Resick, P. A. (1992). Cognitive-behavioral treatment approaches for victims of crime. In P. A. Keller & S. R. Heyman (Eds.), *Innovations in clinical practice: A source book* (11, pp. 23-38). Sarasota, FL: Professional Resource Exchange.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, 60(5), 748-756.

Resick, P. A. (1992). Cognitive treatment of crime-related post-traumatic stress disorder. In R. D. Peters, R. J. McMahon, & V. L. Quinsey (Eds.), *Aggression and violence throughout the life span* (pp. 171-191). Newbury Park, CA: Sage Publications.

Classification Rating: 3

Eye Movement Desensitization and Reprocessing (EMDR)

Prepared by Claude Chemtob, Ph.D.

Brief Description:

EMDR is a multi-component therapeutic procedure for traumatic memories and for post-traumatic stress disorder (PTSD) that purports to restart and facilitate blocked processing of the traumatic memory, promote more adaptive cognitions regarding the trauma, and to install alternate positive cognitions, coping strategies, and adaptive behaviors.

Theory and Rationale:

EMDR theory is grounded in adaptive cognitive network theories of learning and emotion (Lang,1977; Bower, 1981) and in Piagetian views of learning in which assimilation and accommodation are seen as key processes in the adaptive efforts of human beings. Shapiro (1995) has proposed an "accelerated information processing" model to account for traumatic memories and for their resolution through EMDR which draws on these traditions. The model is based on a number of key propositions. First, traumatic memories are not fully assimilated into the broader cognitive network which demarcates a person's experience; that is they remain partially associatively isolated from the person's larger life experience. Because such memories are not fully assimilated within the person's pre-existing cognitive schemas, they exert a disequilibrating influence on subsequent information processing. Second, traumatization interferes with psychological and biological processes that normally promote assimilation and accommodation of memories. Trauma memories contain a number of semantic and affective distortions reflecting this partial dissociation from the broader semantic-cognitive network. Storage in this unaccommodated form can impact other processing negatively, leading to distortions in perception, feeling, and response. Third, EMDR theory proposes that there exists within people an intrinsic self-healing mechanism that is activated by the EMDR procedure. The activation serves to dynamically restart the integration of trauma memories and their assimilation into a normalized form. This inherent information processing mechanism is hypothesized to account for extremely rapid treatment related changes. Fourth, EMDR theory extends other information processing theories of PTSD by specifically describing the importance of self-representations in the encoding of trauma memories. Fifth, EMDR theory emphasizes the importance of systematic skill-building to compensate for the trauma's interference with the acquisition of appropriate competencies. While some have proposed that EMDR's effects are accounted for by its exposure component, traditional theories of exposure do not account for the efficacy of the brief duration of the exposure in EMDR. Additional research on EMDR's mode of action is needed.

Adult treatment outcome research indicates that EMDR is efficacious for PTSD, although substantial questions remain regarding its actual mode of action (Chemtob, Tolin, Van Der Kolk, and Pitman, 2000). There are three controlled studies of EMDR with traumatized children or adolescents. All three suggest EMDR is efficacious. Three sessions of EMDR were shown to be effective for disaster-related PTSD compared to a wait list condition in treatment resistant children exposed to a natural disaster (Chemtob, Nakashima, & Carlson, 2002). Two studies of children/young adults with various clinical problems compared two or three sessions of EMDR added to routine care to routine care or to a non-specific intervention. Findings showed that

EMDR produced superior results on measures of memory-related distress as well as other outcomes

Treatment Components:

History and Treatment Planning

- Evaluation of child readiness, barriers to treatment, dysfunctional behaviors, symptoms, and illness characteristics.
- Development of a treatment plan that addresses trauma-specific memories as well as present reminders of the traumatic event and identifies remedial skills needed for the patient's future use. A key decision is whether to address trauma-related memories in caretakers.

Preparation

- Establish an appropriate treatment relationship with the child and caretaker.
- Provide education about trauma and to inform the child and caretaker of the rationale behind EMDR.
- Teach child and caretaker specific coping skills for processing trauma-related material as it emerges.

Assessment

- The child identifies (a) a distressing image in memory, (b) an associated negative cognition, (c) an alternate positive cognition, (d) rates the validity of the positive cognition (VoC), (e) identifies the emotions associated with the traumatic memory, (f) rating the subjective level (or units) of distress (SUD), and (g) identifies trauma-related physical sensations and their bodily location (e.g., a flutter in the stomach). In addition, the child is asked to identify a "safe place" in imagination. This "safe place" is used to establish feelings of safety at the beginning of each session and to reach closure at the end of each session.

Desensitization and Reprocessing

- After imagining the "safe place" identified previously, the child holds in mind the distressing image, the negative cognition, and the trauma-related body sensations while the clinician moves his/her fingers back and forth and the child tracks the fingers with his/her eyes.
- After approximately twenty back-and-forth eye movements, the clinician stops and asks the child to "let go" of the memory, take a deep breath, and report changes in the image, bodily sensations, emotions, or thoughts about the self.

Installation of Positive Cognition

- Once the SUD rating has been reduced as far as possible toward zero (no discomfort), the positive cognition is again assessed using the VoC scale. The child is instructed to think of the target image while holding in mind the positive cognition.
- Another set of eye movements is performed, followed by another assessment of the validity of the positive cognition.
- This cycle is repeated until the VoC rating rises as far as possible

- Specific coping skills designed to deal with past memories and present emotions, as well as optimal behavioral responses to future situations.

Body Scan

- If a check with the child reveals any signs of residual physical tension or discomfort, the child is instructed to attend to the physical sensations while additional sets of eye movements are performed.

Closure

- Prepare the child for leaving each session; techniques such as relaxation or visualization are occasionally used.

Re-evaluation

- Each subsequent session incorporates an assessment of whether treatment goals have been reached and maintained. Trauma-related material that has emerged since the last session is addressed.

Duration of Treatment: 2-3 sessions

Treatment Manual or Protocol Descriptions:

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford.

Greenwald, R. (1993). *Using EMDR with children*. Pacific Grove, CA: EMDR Institute.

Chemtob, C.M. (1995). *Study protocol for treating children with hurricane-related PTSD using EMDR* (unpublished study protocol). 1132 Bishop Street, Suite 307, Honolulu, Hawaii 96813.

Treatment Outcome Study References:

Chemtob, C.M., Nakashima, J., & Carlson, J.G. (2002). Brief Treatment for Elementary School Children with Disaster-related posttraumatic stress disorder: A field study. *Journal of Clinical Psychology, 58*(1), 99-112.

Scheck, M. M., Schaeffer, J. A., & Gilette, C. S. (1998). Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. *Journal of Traumatic Stress, 11*, 25-44.

Soberman, G. S., Greenwald, R., & Rule, D. L. (in press). A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problems. *Journal of Aggression, Maltreatment, and Trauma*.

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Puffer, M. K., Greenwald, R., & Elrod, D. E. (1998). A single session EMDR study with twenty traumatized children and adolescents. *Traumatology*, *3*(2), http://www.fsu.edu/~trauma/v3i2art6.html.

Classification Rating: 3

Individual Child and Parent Physical Abuse-focused Cognitive-Behavioral Treatment

Prepared by David Kolko, Ph.D.

Brief Description:

This treatment is a cognitive-behavioral intervention for children and physically abusive parents that targets beliefs and attributions about abuse and violence, and teaches skills to enhance emotional control and reduce violent behavior.

Theory and Rationale:

Cognitive-behavioral treatments based on the application of social learning principles with their emphasis upon reciprocal influences between parents and children are designed to alter the expression of appropriate or prosocial and inappropriate or deviant behavior. Interventions based on the social-situational model have emphasized instruction and training in new skills in various domains that relate to cognitive, affective, and behavioral development. In working with physically abusive families, such techniques have been directed toward enhancing non-violent discipline, anger control or stress management, and contingency management (see Kolko, 1996a; Kolko, 1996b; Wolfe & Wekerle, 1993). Cognitive-behavioral treatments (CBT) have reported various improvements in parent and child behaviors (e.g., Davis & Fantuzzo, 1989; Whiteman et al., 1987; Wolfe et al., 1988). Children and parents received separate therapists who implement parallel protocols based upon social learning principles designed to address their cognitive, affective, and behavioral-social repertoires (e.g.,Walker, Bonner, & Kaufman, 1988; Wolfe et al., 1981). Treatment is directed toward teaching intrapersonal and interpersonal skills, as most CBT studies have targeted one of these domains (see Wolfe & Wekerle, 1993). Several technical materials were adapted for this protocol (e.g., Feindler & Ecton, 1986; Fleischman, Horne, & Arthur, 1983; Wilson, Cameron, Jaffe, & Wolfe, 1986; Walker et al., 1988; Wolfe et al., 1981).

Treatment Components:

Child:

- Identification of views of family stressors and violence.
- Teaching coping and self-control skills training (e.g., safety/support planning, relaxation).
- Training in interpersonal effectiveness skills to enhance social competence (e.g., using social supports, social skills, and assertion).
- Specific instructions regarding skill use, role-playing exercises, performance feedback, and home practice exercises.

Parent:

- Identification of views on violence and physical punishment, attributional style and expectations.
- Self-control (e.g., anger-control, cognitive coping).
- Contingency management (e.g., attention, reinforcement, time-out).

- Specific instructions regarding skill use, role-playing exercises, performance feedback, and home practice exercises.

Duration of Treatment: 12-16 sessions

Treatment Manuals or Protocol Descriptions:

Kolko, D.J., & Swenson, C.C. (2002). *Assessing and treating physically abused children and their families: A cognitive-behavioral approach.* Thousand Oaks, CA: Sage Publications.

Swenson, C.C. & Kolko, D.J. (2000). Long-term management of the developmental consequences of child physical abuse. In R. Reece (Ed.). *The treatment of child abuse*. Baltimore, MD: Johns Hopkins University Press.

Treatment Outcome Study References:

Kolko, D.J. (1996) Individual cognitive behavioral therapy and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment*, 1, 322-342.

Classification Rating: 3

Resilient Peer Training Intervention

Prepared by John Fantuzzo, Ph.D.

Brief Description:

This is a school-based intervention for young abused children that is based on an ecological model and uses competent peers and parent helpers to increase children's social competence.

Theory and Rationale:

Resilient Peer Training (RPT) intervention is a preschool, classroom-based intervention developed for maltreated children at higher than average risk for maladaptive social functioning. Guided by Fantuzzo's overall Resiliency, Partnership-Directed approach to intervention (Fantuzzo & Mohr, 2000), RPT is designed to enhance the development of social competencies for vulnerable children by capitalizing on the strengths of resilient peers and the natural support provided by teachers and parent volunteers in a therapeutic preschool or Head Start classroom environment. A number of studies have been conducted to evaluate the effectiveness of the RPT intervention for social isolated, low-income preschool children, who have been maltreated (Fantuzzo, et al., 1997). These randomized field tests supported the effectiveness of the RPT intervention. Socially withdrawn maltreated children showed a significant increase in positive interactive peer play behavior and a decrease in solitary play behavior as a result of the RPT Intervention. Treatment gains in observed social interactions were validated by teacher and parent ratings of social functioning. Children who received RPT were found to exhibit significantly higher self-control and interpersonal skills and interactive play. Treatment children also showed significantly fewer incidences of behavior problems than children in the control condition. Additionally, data indicated that the RPT interventions across preschool programs and across studies were implemented with integrity (i.e., treatment carried out as planned at a 90% level or greater) and the evaluation team received a 100% rate of cooperation from participating preschool teachers and support staff.

Treatment Components:

- Selection of a resilient peer (Play Buddy) to pair with a child manifesting peer problems (Play Partner).
- Working with teachers to establish Play Corners in the natural classrooms for dyads to play with minimal distractions. Identifying and training parent volunteers (Play Supporters) from the local preschool setting to support positive play interactions between Play Buddies and Play Partners.
- Daily RPT intervention sessions consisting of a 20-minute play session between the Play Buddy and the Play Partner.
- Observation by the Play Supporter who makes supportive comments at the end of the play session.

Duration of Treatment:

20 play sessions over 8 week period, with booster and follow-up sessions as needed

Treatment Manuals or Protocol Descriptions:

Fantuzzo, J., Weiss, A., & Coolahan, K. (1998). Community-based partnership-directed research: Actualizing community strengths to treat victims of physical abuse and neglect. In R.J. Lutzker (ed.) *Child abuse: A handbook of theory, research, and treatment.* (pp. 213-238) New York, NY: Pergamon Press.

Treatment Outcome Study Reference:

Fantuzzo, J., Sutton-Smith, B., Atkins, M., & Meyers, R. (1996) Community-based resilient peer treatment of withdrawn maltreated preschool children. *Journal of Clinical and Consulting Psychology,* 64, 1377-1368.

Classification Rating: 3

Therapeutic Child Development Program

Prepared by Laura Sheehan, M.A.

Brief Description:

This treatment is a milieu based intervention for maltreated preschool children that seeks to reduce risk factors and enhance protective factors by providing children with positive nurturing interactions with adults and a consistent, safe, monitored environment.

Theory and Rationale:

The therapeutic child development approach is based on research by expert child practitioners and scientists showing that early life experiences and brain development affect later-life functioning. Early maltreatment can alter or stunt brain development (DeBellis, et al, 1999; Perry & Pollard, 1998) and often occurs in the context of disrupted attachment (Cicchetti & Barnett, 1991). Because the most active and critical time of brain development occurs during the first 33 months (9 months' gestation, plus 24 months), and because emotional behavior and impulse control require practice and develop in the context of an attachment relationship to a caregiver, the program treats children at the earliest period of development - birth to five years. This type of program is usually recommended when there are significant concerns about parental capacity to respond appropriately to their young children or where the children are exhibiting substantial developmental lags and an intensive exposure to an alternative environment is considered necessary. It is designed to develop empathy and emotional attachment to others, to learn to control and balance feelings, especially those that can be destructive, to develop capacity for cognitive processes, such as problem solving, and to learn the interactive skills necessary to form other secure relationships. A central mechanism for creating protective factors is providing emotionally attuned primary caregivers that create a growth-promoting environment and help children form emotional attachments to caregivers. Children attend a milieu-based program during the day and parents are provided with some educational and supportive services. In a long-term follow-up, treated children were significantly less aggressive, had fewer internalizing behavior problems, were less frequently arrested for violent and non-violent crimes, and were less often identified as violent by caregivers (Moore, Armsden, & Gogerty, 1998).

Treatment Components:

- Transportation of child to and from the program each day.
- Treatment milieu environment of 9 to 15 children, depending on age of child.
- Emotionally-attuned and responsive caregivers interacting with children.
- Nutritious meals three times a day.
- Healthcare monitoring.
- Developmental therapies as needed; e.g., physical therapy, special education, speech therapy.
- Case management.
- Monitoring of child and family for abuse and neglect, parental substance abuse, compliance with court ordered conditions.
- Parent education and parent support groups.
- Applied parenting instruction.

Duration of Treatment: Variable, can be many months or even years.

Treatment Manuals or Protocol Descriptions:

Childhaven, Inc. (undated). *Childhaven Therapeutic Child Development Manual.* Seattle, WA: Author.

Treatment Outcome Study References:

Moore, E., Armsden, G., & Gogerty, P.L. (1998). A twelve-year follow-up study of maltreated and at-risk children who received early therapeutic care. *Child Maltreatment*, 3, 3-16.

Classification Rating: 3

Trauma-focused Cognitive-Behavioral Therapy (CBT)

Prepared by Judy Cohen, M.D. and Esther Deblinger, Ph.D.

Brief Description:

Trauma-focused cognitive behavioral therapy, an intervention based on learning and cognitive theories, is designed to reduce children's negative emotional and behavioral responses and correct maladaptive beliefs and attributions related to the abusive experiences. It also aims to provide support and skills to help nonoffending parents cope effectively with their own emotional distress and optimally respond to their children.

Theory and Rationale:

Cognitive-behavioral therapy (CBT) is based on the premise that symptoms develop and are maintained, at least in part, by conditioned and learned behavioral responses as well as maladaptive cognitions (Brewin, 1989). The model emphasizes the interdependence of thoughts, behaviors, feelings as well as physiological responses. Thus, interventions designed to target any one of these areas of functioning are expected to indirectly impact on adjustment in the other areas of functioning as well. Treatment plans are based on comprehensive assessments and are individually tailored to address the clients' specific needs. The rationales for the use of CBT interventions are full explained to clients so that they can be active participants in developing and applying interventions in session and at home.

CBT has had demonstrated efficacy in addressing symptoms such as depression, anxiety and panic attacks in adults and children (Lipsey & Wilson, 1993; Weisz, Weiss, Han, Granger, & Moreton, 1995). CBT and behavioral interventions are the treatments of choice for behavior problems in children (Weiss & Weisz, 1995). Trauma-focused CBT was initially developed for adult survivors of trauma and has been proven effective for PTSD symptoms in studies with adults (Rothbaum, et al., 2000). The success of CBT in treating these groups led to the adaptation of trauma-focused CBT for children and adolescents. The treatment focuses on conditioned emotional associations to memories and reminders of the trauma, distorted cognitions about the event(s), and negative attributions about self, others and the world. Nonoffending parents are included in the treatment process to enhance support for the child, reduce parental distress, and teach appropriate strategies to manage child behavioral reactions. In the latter stages of therapy, family sessions that include siblings may also be conducted to enhance communication. Trauma-focused CBT has been proven effective for children exposed to a variety of traumatic events and has received the strongest empirical support from studies with abused children (American Academy of Child and Adolescent Psychiatry, 1998). It has been used in individual, family, and group therapy and in office-based and school-based settings.

Treatment Components:

- Psychoeducation about child abuse, typical reactions, safety skills and healthy sexuality.
- Gradual exposure techniques including verbal, written and/or symbolic recounting (i.e. utilizing dolls, puppets, etc.) of abusive event(s).
- Cognitive reframing consisting of exploration and correction of inaccurate attributions about the cause of, responsibility for, and results of the abusive experience(s).

- Stress management techniques such as focused breathing and muscle relaxation exercise, thought stopping, though replacement, and cognitive therapy interventions.
- Parental participation in parallel or conjoint treatment including psychoeducation, gradual exposure, anxiety management and correction of cognitive distortions.
- Parental instruction in child behavior management strategies.
- Family work to enhance communication and create opportunities for therapeutic discussion regarding the abuse.

Duration of Treatment: 12-16 sessions

Treatment Manuals or Protocol Descriptions:

Deblinger, E., & Heflin, A.H. (1996). *Treatment for sexually abused children and their non-offending parents: A cognitive-behavioral approach*. Thousand Oaks, CA: Sage.

Cohen, J.A., Mannarino, A.P. (1993). A treatment model for sexually abused preschoolers. *Journal of Interpersonal Violence, 8*, 115-131.

Treatment Outcome Study References:

Berliner, L. & Saunders, B.E. (1996). Treating fear and anxiety in sexually abused children: Results of a controlled 2-year follow-up study. *Child Maltreatment, 1*(4), 294-309.

Celano, M., Hazzard, A., Webb, C., McCall, C. (1996). Treatment of traumagenic beliefs among sexually abused girls and their mothers: An evaluation study. *Journal of Abnormal Child Psychology, 24*, 1-16.

Cohen, J.A., & Mannarino, A.P. (1996). A treatment outcome study for sexually abused pre-school children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 42-50.

Cohen, J.A., & Mannarino, A.P. (1997). A treatment study of sexually abused preschool children: Outcome during a one year follow-up. *Journal of the Academy of Child and Adolescent Psychiatry, 36*(9), 1228-1235.

Cohen, J.A., & Mannarino, A.P. (1998). Interventions for sexually abused children: Initial treatment findings. *Child Maltreatment, 3*, 17-26.

Deblinger, E., McLeer, S. V. & Henry, D. (1990). Cognitive behavioral treatment for sexually abused children suffering post-traumatic stress: Preliminary findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 19*, 747-752.

Deblinger, E., Lippmann, J., & Steer, R. (1996) Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*, 310-321.

Stauffer, L. & Deblinger, E. (1996). Cognitive behavioral groups for nonoffending mothers and their young sexually abused children: a preliminary treatment outcome study. *Child Maltreatment, 1*(1), 65-76.

Deblinger, E., Steer, R.A., & Lippmann, J. (1999). Two year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. *Child Abuse & Neglect, 23*(12), 1371-1378.

Classification Rating: 1

Trauma-focused Integrative-Eclectic Therapy (IET)

Prepared by William Friedrich, Ph.D.

Brief Description:

IET is a psychosocial intervention based on data suggesting that persistent effects of trauma and maltreatment are best understood as a function of both the child and the child's relationships and living context. It is designed to increase safety in the home, enhance the quality of the parent-child relationship, and assist the child or teenager in the acquisition of more accurate self-perceptions and coping strategies.

Theory and Rationale:

Integrative-eclectic therapy (IET) is based on a number of principles from developmental psychopathology (Cicchetti & Carlson, 1989). The first is that the child is embedded in the family context (Kegan, 1982), and that the security of parent-child attachment is a key to the child's adaptive functioning and resilience in the face of adversity (Egeland, Jacobvitz, & Sroufe, 1988). A second principle is that maltreatment experiences are dysregulating (Siegel, 1999) and are directly related to a range of symptoms that typically need to be addressed. Finally, the developing organism is increasingly an observer of self (Harter, 1986), and accuracy of self-perception will facilitate long-term coping and allow for necessary psychological-mindedness to bring to future situations (Calverly, Fischer, & Ayoub, 1994).

IET is grounded in a substantial body of research (Friedrich, 1995). For example, it draws on the initial portion of Parent-Child Interaction Therapy that is designed to enhance the nonabusive parent-child relationship via the utilization of child-directed play activities (Hembree-Kigin & McNeil, 1995). A number of attachment related issues can be addressed including sensitive parenting, commitment to the child's welfare, the reduction of intrusive parenting, and the increase in positive attention. Sensitive parenting is also reflected in the safety of the child's house, and the accuracy with which the parent views the child. In addition, parents of maltreated children are typically multiply entrapped in their family of origin as well as with helping professionals and court and social services.

Symptoms of dysregulation have been effectively treated by cognitive behavior therapy (CBT) that combines exposure and the instruction in relaxation or imagery skills. IET goes beyond most CBT-based programs in that the parent-child relationship also is addressed along both cognitive and relational dimensions. (Please note: Some CBT programs for abused children also include interventions for parent-child relationships, e.g., Deblinger & Heflin, 1996). In addition, behavioral strategies can be effectively used to address other symptoms of dysregulation, including sexual behavior problems, and anger. Sensitivity to the intervention strategy also is needed so that the child does not become more agitated and/or out of control with the treatment. Finally, the accuracy of both the child's and parent's self-perception is also a developmentally related construct that assumes greater importance, as the individual grows older. The intervention is designed to address issues of shame, self-blame, and potency along with an understanding of self-in-relationships. IET was developed in work with disadvantaged families that were both therapy illiterate and avoidant; it is goal-based in order to make therapy more understandable and reinforcing. Treatment length is variable.

Treatment Components:

- Identify all parties that are involved in the family's life and develop a coordinated treatment plan.
- Identify specific goals in the areas of parent-child attachment and safety in the home that must be addressed in the course of treatment.
- Set treatment goals in the areas of safety and parent-child connection.
- Address issues of safety that further trigger the child and concretely help the parent show commitment to the child's welfare.
- Enhance the quality of the parent-child relationship via child-directed interaction.
- Correct the inaccurate perceptions the parent has of the child.
- Help the parent to realize how their own disadvantaged upbringing influences their parenting and address as possible.
- Help child and parent to realize links between thoughts, feelings, and behaviors.
- Teach alternate strategies of coping including relaxation, imagery and self-talk.
- Once the parent-child relationship has improved, teach developmentally appropriate behavior management strategies.

Duration of Treatment: Variable, generally over a period of months

Treatment Manuals or Protocol Descriptions:

Friedrich, W.N. (1995). *Psychotherapy with sexually abused boys*. Thousand Oaks, CA: Sage.

Friedrich, W. N. (1998). *Treating sexual behavior problems in children: A treatment manual*. Available from the author at the Mayo Clinic, Department of Psychiatry and Psychology, Rochester, MN 55905.

Treatment Outcome Research References:

Friedrich, W. N., Luecke, W. J., Beilke, R. L., & Place, V. (1992). Group treatment of sexually abused boys: An agency study. *Journal of Interpersonal Violence*, *7*, 396-409.

Classification Rating: 3

Trauma-focused Play Therapy

Prepared by Eliana Gil, Ph.D.

Brief Description:

This treatment is a psychotherapeutic intervention that uses play as a mechanism for allowing abused children to use symbols (toys) to externalize their internal world, project their thoughts and feelings, and process potentially overwhelming emotional and cognitive material from a safe distance.

Theory and Rationale:

Play has been chronicled as a vehicle to help children with tasks such as mastery, problem-solving and conflict resolution, communication, affective expression, cognitive stretching, developmental strides, and relational issues (Schaefer, 1993). Therapeutic play is used by trained professionals as a tool for assisting children with a range of psychosocial problems. Guided by a strong belief in the curative qualities of play, trauma-focused play therapists carefully select toys that will allow the child to symbolize or literally recreate elements of the trauma experience so that it may be processed and integrated. Therapeutic play can therefore be considered the child's natural way of experiencing gradual exposure, a cognitive-behavioral strategy for addressing anxiety or fear. Through post-traumatic play, traumatized children expose themselves to the story, scenario, or behavioral sequence they may fear, avoid or misunderstand (Gil, 1991). Through this external reconstruction they are able to contain and manage otherwise overwhelming and fragmented affect and cognition. Trauma-focused play often gives way to affective discharge, cognitive evaluation, and frees up psychic or emotional energy that is bound by traumatic memories. The trauma-focused play therapist witnesses the child's reality, provides unconditional acceptance of the child's feelings, thoughts, and reactions, challenges cognitive distortions and promotes empowerment and resiliency.

Treatment Components:

- Selection and display of appropriate toys and miniatures based on the particular child's traumatic situation.
- Giving therapeutic permission and encouragement to move at the child's own pace.
- Observation and recording of the child's post-trauma play and accompanying affect.
- Reflective commenting on the child's post-trauma play or therapeutic questions that ask the child to expand on narrative already provided of play.
- Assisting with clarification, processing of idiosyncratic meaning, affect discharge, sequential organization and integrating of difficult cognitions and affect.
- Helping the child manage anxiety, develop new coping strategies, and identify external resources.
- Providing parental support and education as well as guidelines for observing and participating in child's every day play without over-interpreting and/or becoming intrusive.
- Collateral individual therapy for parents, particularly if prior abuse issues interfere with current abilities to address their child's needs for safety and support.

Duration of Treatment: Variable, generally over a period of months

Treatment Manual or Protocol Descriptions:

Gil, E. (1991). *The Healing Power of Play*. New York: Guilford Press

Gil, E. (1996). *Treating Abused Adolescents*. New York: Guilford Press.

Gil, E. (1998). *Essentials of Play Therapy with Abused Children*. New York: Guilford Press.

Treatment Outcome Research References:

None

Classification Rating: 4

Family, Parent-Child and Parent-Focused Interventions

Attachment-Trauma Therapy

Prepared by Beverly James, MSW and Karen Sitterle, Ph.D.

Brief Description:

This treatment is a multidimensional intervention with the primary goal of creating or restoring a secure primary attachment relationship for the child and caretaker using positive affective and sensori-motor interactions designed to establish the experience of safety and attunement within with matrix the child and parent are helped to process the traumatic event.

Theory and Rationale:

Attachment and trauma problems are often interwoven for children in instances such as the loss of a primary attachment figure, experiencing or witnessing violence, or when a traumatizing experience results in serious disturbance in the attachment relationship. Research and clinical experience demonstrate that the quality of the attachment relationship influences all aspects of a child's development (Winnicott, 1960; Bowlby, 1969; Ainsworth, 1973; Stern, 2000; Zeanah & Scheeringa, 1996). Abnormal developmental attachment patterns can result from significant problems in the infant-parent relationships (Greenspan and Lieberman, 1988). Trauma can cause developmental problems as well (Pynoos, Steinberg, & Wraith, 1995). The combined impact of attachment-trauma problems often produce serious developmental injuries in forming and maintaining interpersonal relationships (Crittenden, 1988; Lieberman & Pawl, 1988; Cicchetti, 1989), in affect regulation (Schore, 1994; Terr, 1994; Crittenden & Ainsworth, 1989; Perry, 1995), neurological and structural brain development (Perry, 1995; Schore, 1994), language development (Greenspan & Lieberman, 1988; Cicchetti, 1989), language and emotional language usage (Cicchetti, 1989; Chicchetti, Cummings, Greenberg, & Marvin, 1990; Kobac, 1993; Schore, 1994).

Attachment-trauma therapy is based on the premise that children need to experience safety in an attachment relationship in order to adequately cope with traumatizing experiences (Fraiberg, 1975; James, 1989a: James, 1989b; Pearce & Pezzot-Pearce, 1997). The need for stimulation of the affective and motor system in facilitating a positive attachment relationship is supported by neurophysiological research (Perry, 1995) and in research with very young children who witness family violence (Osofsky & Fenichel, 1994; Gaensbauer & Siegel, 1995). Children's symptoms of avoidance, dysregulated affect, automatic response to perceived threat, and dysfunctional behavioral adaptations create barriers to formation of new attachment relationships and from coping with trauma (James, 1994; Hughes, 1997). Barriers for parents in forming a secure attachment with the child include fear, ignorance of attachment-trauma dynamics, disappointment and despair related to the child, and their own pathological behaviors (Herman, 1992; James, 1994). Therapy is designed to build a foundation of pleasure in the relationship, create emotional and physical attunement, promote emotional competency, reduce stress, increase communication and trust, increase awareness and insight, help children master traumatic experiences, enhance authentic communication and generally strengthen the attachment bond. Treatment length is variable.

Treatment Components:

- Psychoeducation about attachment, development, trauma, adaptive and survival behaviors.
- Directed positive affective and sensori-motor activities between caregiver and child in session and at home.
- Use of drama, metaphor, and movement interventions to identify, differentiate, manage, increase and practice a range of emotional expression.
- Stress management and focusing techniques including yoga, deep breathing, muscle relaxation, and imagery.
- Cognitive and expressive arts interventions.
- Family play and behavioral interventions.
- Focused trauma-loss work using play therapy techniques in small manageable pieces.
- Family ritual and commemoration interventions when a relationship has been lost.
- Family discussions to celebrate accomplishments, anticipate future problems, identify tools to handle them, and plan for regular check-ups.
- Graduation ceremony.

Duration of Treatment: Variable, generally over a period of months

Treatment Manuals or Protocol Descriptions:

James, B. (1994). *Handbook for treating attachment-trauma problems in children*. New York, NY: Free Press/Simon & Schuster.

Treatment Outcome Study References:

None

Classification Rating: 4

Behavioral Parent Training Interventions for Conduct-Disordered Children

Prepared by Elizabeth Brestan, Ph.D. and Holly Payne

Brief Description:

Behavioral parent training encompasses several treatment protocols that target behavior-disordered children and their families. They typically use a short-term behavioral intervention and usually involve teaching parents skills based upon behavior theory designed to increase child compliance, decrease child disruptive behavior, and minimize coercive interactions between parent and child at home and in other settings.

Theory and Rationale:

Maltreated children often display disruptive behaviors that may be the result of maltreatment or stem from disordered family interactions (Hersen & Ammerman, 1990; Lutzker, Van Hasselt, Bigelow, Greene, & Kessler, 1998; Stern & Azar, 1998) Child behavior problems may contribute to risk for maltreatment as well (Hersen & Ammerman, 1990; Lutzker, et al., 1998). Treatments designed to change parenting practices are, therefore, considered risk reduction strategies as well as responses to the children's behavior problems. These interventions differ from didactic "parenting" classes in that they are based on established principles of behavior change and involve teaching skills in addition to conveying information. Approximately 40% of such interventions are manualized treatments and a recent review of effective psychosocial treatments for conduct-disordered children found several of these treatment "packages" to have empirical support for their efficacy (Brestan & Eyberg, 1998). A number of different approaches have been developed and tested.

G. R. Patterson's *Living With Children*. Parent training programs based on Patterson and Gullion's (1968) manual *Living with Children* rely on operant principles of behavior change and teach parents to monitor targeted deviant behaviors, monitor and reward incompatible behaviors, and ignore or punish deviant behaviors of the child. This 6 to 8 session approach is based on Patterson's coercion theory (1982) and is designed to interrupt the coercive patterns of interactions that are hypothesized to occur between parents and their conduct-disordered children. This treatment includes a companion book for parents, *Living with Children* (1976), which is often used in conjunction with parent training. Efficacy studies using Patterson's treatment approach have included boys and girls between the ages of 6 and 16 years with conduct-disordered behavior. This treatment has been found to be superior to control groups in several controlled studies (Alexander & Parsons, 1973; Bernal, Klinnert, & Shultz, 1980; Firestone, Kelly, & Fike, 1980; Wiltz & Patterson, 1974). Based on the strong empirical support for Patterson's approach, a recent review conducted as part of the American Psychological Association's (APA) Division 12 Task Force on Effective Psychosocial Interventions judged this treatment as meeting the stringent criteria for "well-established" psychosocial interventions for childhood disorders (Brestan & Eyberg, 1998; see Lonigan, Elbert, & Johnson, 1998 for review of criteria).

R. L. Forehand's Social Learning Parent Training. Forehand's Social Learning Parent Training approach is outlined in his 1981 manual, *Helping the Noncompliant Child*. This

10-session treatment approach is based on social learning theory principles and procedures developed by Constance Hanf at the University of Oregon Health Sciences Center (Hanf, 1968; Hanf, 1969). The Social Learning Parent Training approach teaches parents to modify maladaptive parent-child interactions by learning how to attend to positive behavior and effectively deal with child disruptive behavior. Efficacy studies using Forehand's treatment approach have included boys and girls between the ages of 3 and 8 years with noncompliant behavior. This treatment approach has been found to be superior to control groups in several controlled studies (Peed, Roberts, & Forehand, 1977; Wells & Eagan, 1988). Based on the empirical support for Forehand's approach, the APA Division 12 Task Force on Effective Psychosocial Interventions judged this treatment as meeting the criteria established for "probably efficacious" psychosocial interventions for childhood disorders (Brestan & Eyberg, 1998).

R. A. Barkley's *Defiant Children*. Barkley's treatment approach is also based on social learning theory principles and procedures developed by Hanf (Hanf, 1968; Hanf, 1969). This program provides behavior management training to parents of children with noncompliance and attentional problems. Although Barkley (1997) describes this treatment as being optimal for children with oppositional behavior and attention deficit hyperactivity disorder (ADHD) between the ages of 2-12 years and numerous studies are cited for the treatment components included in *Defiant Children*, no empirical studies have addressed the efficacy of this particular treatment protocol for the 2 to 12 age group. One empirical study comparing Barkley's approach to problem solving/communication training and structural family therapy has provided evidence for the efficacy of this treatment for adolescents with ADHD between the ages of 12-17 years (Barkely, Guevremont, Anastopoulous, & Fletcher, 1992). Barkley's use of a token economy makes this treatment well suited for children with ADHD who respond well to regular and predictable reinforcement (Newby et al., 1991).

A. E. Kazdin's "Parent Management Training (PMT)" and "Cognitive-Behavioral Problem-Solving Skills Training (PSST). Kazdin's Parent Management Training (PMT) approach is a manual-based treatment for parents of children with disruptive behavior disorders (Kazdin, Siegel, & Bass, 1992). PMT is based on a conceptual model that accounts for the parenting practices and parental cognitive processes that serve to reinforce and maintain disruptive behavior disorders among children. This 16-session treatment approach was originally based on Patterson's *Living with Children* program, but was broadened to include cognitive correlates to child antisocial behavior. Kazdin's Cognitive-Behavioral Problem-Solving Skills Training (PSST) approach is a manual-based treatment for children with antisocial behavior targeting the cognitive processes that mediate the child's maladaptive interpersonal behavior. Treatment outcome research has found that although PMT alone decreased child antisocial behavior problems, PMT combined with PSST was more effective at the follow-up assessment (Kazdin, Siegel, & Bass, 1992). The combined PMT and PSST treatment was also superior to a contact-control group (Kazdin, Esveldt-Dawson, French, & Unis, 1987). Efficacy studies for Kazdin's PMT and PSST have included both outpatient and inpatient children between the ages of 7 and 13 years meeting the DSM-III-R criteria for ADHD, Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), or Adjustment Disorder (Kazdin, Esveldt-Dawson, French, & Unis, 1987; Kazdin, Siegel, & Bass, 1992). Although PMT may be an effective treatment in its own right, the APA Division 12 Task Force on Effective Psychosocial Interventions judged the combined PMT and PSST treatment to meet the criteria

established for "probably efficacious" psychosocial interventions for childhood disorders (Brestan & Eyberg, 1998).

Treatment Components:

Living with Children components

- Sessions typically conducted without the child.
- Instruction on social learning theory and coercive theory.
- Instruction on how to monitor and record the child's behavior.
- Use of point system to promote appropriate behavior.
- Use of positive social reinforcement.
- Instruction on how to make effective requests.
- Use of punishment (time out, selective ignoring, overcorrection).
- Booster sessions.

"Social Learning Parent Training" components

- Sessions typically conducted with both parent and child.
- Instruction on social learning theory, the "negative reinforcement trap," and the "positive reinforcement trap."
- Includes shaping parent's expectations for child compliance .
- Instruction on how to use contingent social reinforcement with the child.
- Modeling, role play, and direct communication with parent while he/she interacts with the child in the clinic setting.
- Daily practice of techniques ("Child's game," "Parent's game"), homework assignments.
- Instruction on how to give effective commands.
- Use of punishment (time out).
- Coded home and clinic observations.

"Defiant Children" components:

- Easily conducted in a group format.
- Sessions typically conducted without the child.
- Instruction on social learning theory and the causes of child misbehavior.
- Instruction on how to use social reinforcement and use shaping to increase positive behavior.
- Instruction on how to use incentive programs (behavior charts, token economy).
- Daily practice of techniques (special nondirective playtime procedure, compliance training), homework assignments.
- Instruction on how to give effective commands.
- Use of punishment (time out).

Kazdin's Parent Management Training (PMT) components

- Sessions typically conducted without the child.
- Sessions include didactic instruction, modeling, role play, and audiotapes of problematic parent-child interactions.
- Instruction on how to observe and define behavior.
- Instruction on how to use positive reinforcement to shape child's behavior.
- Instruction on how to negotiate and use behavioral contracts.

- Use of punishment (time out) and reprimands.
- Use of special contingencies for low-rate behavior.
- School consultation.
- Use of reinforcers contingent on school behavior.

Kazdin's Cognitive-Behavioral Problem-Solving Skills Training (PSST) components

- Sessions are conducted with the child individually.
- Focuses on problem solving and perspective taking skills.
- Utilizes practice, modeling, role-play, corrective feedback, and social reinforcement.
- Utilizes a token economy in session.
- Homework assignments.

Duration of Treatment: 12-16 weeks

Treatment Manuals or Protocol Descriptions:

Barkley, R. A. (1997). *Defiant children: A clinician's manual for assessment and parent training*. Guilford Press: New York.

Forehand, R. L., & McMahon, R. J. (1981). *Helping the noncompliant child: A clinician's guide to parent training*. Guilford Press: New York.

Patterson, G. R. (1976*). Living with children: New methods for parents and teachers.* Champaign, IL: Research Press.

Patterson, G. R., & Gullion, M. E. (1968). *Living with children: New methods for parents and teachers*. Champaign, IL: Research Press.

Treatment Outcome Study References:

Alexander, J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology,* 81, 219-225.

Barkley, R. A., Guevremont, A. D., Anastopoulos, A. D., & Fletcher, K. E. (1992). A comparison of three family programs for treating family conflicts in adolescents with Attention-Deficit Hyperactivity Disorder. *Journal of Consulting and Clinical Psychology*, 60, 450-462.

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Firestone, P., Kelly, M. J., & Fike, S. (1980). Are fathers necessary in parent training groups? *Journal of Clinical Child Psychology*, *9*, 44-47.

Hughes, R. C., & Wilson, P. H. (1989). Behavioral parent training: Contingency management versus communication skills training with or without the participation of the child. *Child & Family Behavior Therapy, 10*, 11-23.

Kazdin, A. E., Esveldt-Dawson, K., French, N. H., & Unis, A. S. (1987). Effects of parent management training and problem-solving skills training combined in the treatment of antisocial child behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 26*, 416-424.

Kazdin, A. E., Siegel, T. C., & Bass, D. (1992). Cognitive problem solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology, 60*, 733-747.

Peed, S., Roberts, M., & Forehand, R. (1977). Evaluation of the effectiveness of a standardized parent training program in altering the interaction of mothers and their noncompliant children. *Behavior Modification, 1*, 323-350.

Wells, K. C., & Egan, J. (1988). Social learning and systems family therapy for childhood oppositional disorder: Comparative treatment outcome. *Comprehensive Psychiatry, 29*, 138-146.

Wiltz, N. A., & Patterson, G. R. (1974). An evaluation of parent training procedures designed to alter inappropriate aggressive behavior of boys. *Behavior Therapy, 5*, 215-221.

Classification Rating: 3

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Corrective Attachment Therapy

Prepared by Forrest Lien, LCSW, ACSW

Brief Description:

Corrective Attachment Therapy (the Evergreen Model) is a unique synthesis of many different techniques which are employed to facilitate the development of attachment between child and parent. These are rooted in an understanding of neurobiological factors, the function of memory, the effects of trauma, grief and loss, and the critical importance of attachment to the healthy development of a child. Treatment occurs within the context of a safe, nurturing, and respectful environment.

Theory and Rationale:

This treatment is based on the premise that children who have not developed an attachment to a primary caregiver during the first 2-3 years of life are arrested in their development, as indicated by lack of trust, inability to give and receive genuine affection, lack of reciprocity in relationships, lack of cause and effect thinking, lack of remorse after hurting others, as well as manipulative, aggressive and destructive behavior. The treatment presupposes that these children do not benefit from traditional talk or play therapy that relies on mutual trust, internal conflict, and emotional honesty and that they have their greatest difficulty in family settings, where respect and reciprocal interactions are expected. Finally, there is the belief that these children, left untreated, become over-represented in the prison and criminal justice population, domestic violence situations, homeless and mental health populations.

Treatment Components:

- Contracting
- Cognitive restructuring
- Role modeling
- Behavioral shaping
- EMDR
- Emotional cathartic therapy
- Psycho-educational therapy
- Affect regulation (helping a child learn to go in and out of intense emotions and gaining the ability to regulate and to handle these emotions)
- Holding therapy (using a cradling hold such as you would hold and nurture an infant)
- Parent/child bonding techniques
- Psycho-drama
- Guided imagery
- Structural family therapy
- Sibling therapy
- Couples therapy
- Existential psychotherapy
- Legacy recognition and restructuring (re-decision therapy)
- Gestalt therapy
- Journaling

- Paradoxical techniques
- Taking a moral inventory
- Making amends
- Life scripting
- Medication therapy
- Motivational therapy (body training)
- Sex offender treatment
- Therapeutic foster care environment (milieu therapy)
- Parent training
- Therapist training

Duration of Treatment: unspecified

Treatment Manuals or Protocol Descriptions:

ATTACh (Association for Treatment and Training in the Attachment of Children). (undated). *Standards of Practice*. (See www.attachmentcenter.org for information).

Treatment Outcome Research Studies:

None

Classification Rating: 6

Family Focused, Child Centered Treatment Interventions in Child Maltreatment

Prepared by M. Elizabeth Ralston, Ph.D. and Polly B. Sosnowski, MSW

Brief Description:

Focused Treatment Interventions (FTI) is a protocol of sequential treatment interventions focused on increasing child safety, reducing risk and clarifying responsibility in child maltreatment cases. FTI is designed for use in a coordinated multidisciplinary community system of care. The goals of FTI are to identify and reduce barriers to child safety and protection following the disclosure or discovery of maltreatment and to prevent future abuse. The sequential nature of the interventions is based on Finkelhor's (1984) pre-conditions of motivation, internal, external and child factors as applied to a protective family system.

Theory and Rational:

FTI is based on guiding principles from the empirical literature on the impact of child maltreatment, child protection state and federal mandates and supports the overarching goal of family reunification with preconditions of child safety and personal responsibility for behavior. A uniform and comprehensive forensic and clinical assessment in response to suspected maltreatment involving the non-offending caregiver and child victim provides a baseline of history and experience of the child and family. The assessment process is based on the underlying philosophy that parents and adults are responsible for child protection; the empirical literature regarding techniques for forensic interviewing; and the American Professional Society on the Abuse of Children guidelines for conducting psychosocial assessments and forensic interviews in cases of child maltreatment (American Professional Society on the Abuse of Children, 1997).

The guiding principles of FTI support beliefs that the safety of the child is paramount; that family strengthening and reunification are the desired outcomes of community interventions; the safety of the child is a precondition to family reunification; adults are accountable for any abusive and /or neglectful behaviors toward their children; acknowledgment of responsibility for protection and safety is required from the adult caregivers; family strengths and resources in support of safety and protection are the primary focus of interventions; barriers to future safety and protection must be identified and overcome in support of family reunification; necessary community resources are key to supporting the family in overcoming any identified barriers to safety and protection of the child; contact between child victims and adults who have not been treated and who do not acknowledge responsibility for their abusive or neglectful or nonprotective behavior is not in the child's best interest; a uniform assessment that focuses on identification of family strengths, risk factors for child safety, and the impact of abuse or neglect guides the focused interventions in support of family reunification; the overarching goal of focused interventions is reducing child safety risk and rapid, safe preservation of the child with family members or safe rapid reunification of the child with a protective caregiver; and when the goal of family reunification is not possible, early permanency planning is in the best interest of the child.

This model focuses on specific factors that created risk to the child and family and identifies the required behavioral outcome to reduce that risk. Rather than providing a menu of services that require participation to be considered successful, the FTI focuses on identifying risk factors and required behavioral change, and uses input from the caregiver regarding what will be needed to make the required change. For example, when alcohol use is identified as a barrier to child safety/protection, the FTI directs a specific change in alcohol use behavior. The caregiver is involved in what will be required to stop using alcohol in support of the safety and protection of their child. Not using alcohol or not being incapacitated by alcohol is the observable behavior for success vs. participation in an evaluation or alcohol program for a given length of time. If the caregiver does not acknowledge alcohol use as a problem or exhibits no motivation to stop using alcohol, the focused intervention would be on overcoming barriers to motivation vs. forced participation. This system of interventions focuses the responsibility for change on the caregiver (client) and places the responsibility for providing the resources to support that change on the system. This clarifies roles and responsibilities between the "community system" and the family system and is consistent with the most recent federal mandate and provides documentation regarding reasonable effort.

Treatment Components:

- Comprehensive Assessment
- Forensic Medical Exam
- Child Safety and Risk Assessment
- The Focused Intervention Decision Tree
- Protection Clarification
- Abuse Clarification
- Overcoming Internal Barriers
- Overcoming External Barriers
- Reducing child factors that have contributed to placing the child at risk
- Family Meeting
- Identify family and community resources for support regarding child safety/protection
- Develop new safety rules, boundaries, roles, and responsibilities between non-offending caregiver and children within the family and offending caregiver and children within the family
- Monitor family adherence to new rules, alignment of roles, responsibilities
- Community Case Review Staffing
- Individual treatment
- Offender treatment group
- Non-offending caregiver support group
- Victim support group
- Couple treatment
- Protection Clarification
- Abuse Clarification
- Structured family visitation
- Family Therapy

Duration of Treatment: 6 to 12 months, dependent upon response of clients

Treatment Manuals and Protocol Descriptions:

Ralston, M.E. (1998). A community system of care for abused children and their families. *Family Futures, 2*(4), 11-15.

Ralston, M.E. (1982). *Intrafamilial Sexual Abuse: A community system response to a family system problem.* Charleston, SC: Author.

Ralston, M.E., & Swenson, C.C. (1996). *The Charleston Collaborative Project: Intervention Manual.* Charleston, SC: Author.

Lipovsky, J., Swenson, C.C., Ralston, M.E., & Saunders, B.E. (1998). The abuse clarification process in the treatment of intrafamilial child abuse. *Child Abuse & Neglect, 22*(7), 729-741.

Treatment Outcome Study References:

Swenson, C.C., & Ralston, M.E. (1997). *The Charleston Collaborative Project, Implementation Manual.* Charleston, SC, Author.

Classification Rating: 3

Family Resolution Therapy (FRT)

Prepared by Benjamin E. Saunders, Ph.D. and Mary B. Meinig, MSW

Brief Description:

Family Resolution Therapy (FRT) is a protocol of procedures designed to help families where sexual or physical abuse has occurred to develop a long-term resolution for family relationships. It is concerned with the latter stages of the treatment process with abusing families and deals with constructing safe, functional, and stable family structures and processes that will continue well after professional intervention with the family is completed. Resolution outcomes may range from full family reunification to termination of all parent-child contact. FRT seeks to maintain an appropriate level of safety for children while enabling children to maintain the benefits of continuing parent-child relationships where possible.

Theory and Rationale:

FRT is based upon several assumptions drawn from the principles of family systems theory-based family therapy, family and child development, social learning theory, and theories of relapse prevention. First, FRT assumes that the growth and development of children is best promoted when they live in a safe, functional, supportive, and stable family environment, preferably with their parents. Second, most children develop a lifelong psychological bond or attachment to their parents that remains even if their parents are abusive, separated from the child, or incarcerated. Third, many abused children want to continue a relationship with their parents, though they want the abuse to end and its effects remedied. The FRT protocol assumes that the child victim, offending parent, and nonoffending parent have been in appropriate victim, offender, and nonoffending parent therapy programs, and have progressed successfully in those therapies. FRT outcomes (no contact, minimal contact, significant contact, or reunification) will depend upon the level of emotional connection children feel for abusive parents, their desire to maintain their family relationships in some form, and the response of the family to treatment.

The Family Resolution Therapy protocol seeks to develop a long term familial context and functional processes where children can be safe from abuse, yet continue to benefit from some type of relationship with their abusive parents. This long term familial outcome may range from family reunification and maintenance of an intact family, to family separation with unsupervised visitation, to family separation with supervised visitation, to a complete ending of the parent-child relationship. FRT employs psychoeducation and cognitive therapy procedures to change distorted thinking among and between all family members about the abuse experiences and beliefs that supported the abusive context. It employs family therapy techniques to alter the homeostatic organizational functioning, internal boundaries, and external boundaries (i.e., social isolation) of the family system that tended to support and enable the abuse. It employs behavioral management and collateral monitoring techniques to assess, change, and monitor behavior among all family members (particularly the offending parent) and the family system as a whole that may signal a relapse to problem behavior patterns, abusive behaviors, and abuse supportive behaviors. FRT attempts to change familial behavior by altering the familial structure and power hierarchy, changing daily family processes, introducing new ways of conducting familial relationships, and carefully monitoring how new behaviors are implemented

in the family. It makes use of behavioral contracts and collateral surveillance of family functioning and individual behavior, as well as psychotherapeutic modalities.

Treatment Components:

- Monitoring progress of all family members in their individual or group treatment programs. Insure that victim and offender are in appropriate treatment.
- Work closely with victim and offender therapists to assess progress and readiness to proceed with FRT.
- Dyadic therapy with the nonoffending parent and child victim to improve support and trust
- Family therapy with nonoffending parent and sibling group to build familial structural and process change apart from the offending parent.
- Clarification process.
- Implementing criteria for initiating therapeutic contacts between the victim and offender.
- Teach and implement Family Contact Rules.
- Teach and implement Behavioral Alert List..
- Implement a Chaperone or Collateral Behavioral Monitoring Program.
- Structured family visitation program.
- Pre-resolution family therapy
- Implement resolution decision-making process.
- Post-resolution family therapy.

Duration of Treatment: 6 to 18 months

Treatment Manuals and Protocol Descriptions:

Saunders, B. E., & Meinig, M. B. (2000). Immediate issues affecting long term family resolution in cases of parent-child sexual abuse. In R.M. Reece (Ed.). *Treatment of Child Abuse: Common Ground for Mental Health, Medical, and Legal Practitioners*. Baltimore: The Johns Hopkins University Press.

Saunders, B.E., & Meinig, M.B. (2001). *Family Resolution Therapy in Cases of Child Abuse*. Charleston, SC: Authors

Lipovsky, J., Swenson, C.C., Ralston, M.E., & Saunders, B. E. (1998). The abuse clarification process in the treatment of intrafamilial child abuse. *Child Abuse & Neglect, 22*(7), 729-741.

Treatment Outcome Study References:

None

Classification Rating: 4

Integrative Developmental Model for Treatment of Dissociative Symptomatology

Prepared by Joyanna Silberg, Ph. D.

Brief Description:

This is a multi-faceted child and family intervention model for children with dissociative symptoms that emphasizes interrupting automatic dissociative withdrawal, teaching the child alternative communication strategies and affect management techniques, and helping the family learn new interactive patterns.

Theory and Rationale:

Some children with trauma histories may present with symptoms such as trance states, forgetfulness, fluctuating behavior including rapid regressions and rage reactions, and belief in vivid imaginary friends or divided identities (Silberg, 2000). Traumatic events in the child's life may precipitate these adaptations as ways to cope with a dysfunctional environment. These adaptations may be understood as difficulties in the normal developmental integration of self-capacities (Siegel, 1999; Putnam, 1997). Treatment involves emphasis on self-awareness and affect regulation and encouraging the child to take responsibility for actions that the child may initially perceive as outside of his/her control. Interactions with the child emphasize acceptance of all affects, behaviors or dissociated states and the encouragement of self-acceptance as a first step towards self-management. Development of positive fantasy for providing self-soothing illustrates to the child that fantasy, such as belief in malevolent imaginary entities, can be under the child's control. Treatment must keep in mind normal developmental expectations and avoid iatrogenic influences that support the child or family's belief in the literal reality of dissociated identities. Recent research suggests that children with disorganized or avoidant attachment styles may be particularly at risk for developing dissociative symptomatology (Ogawa et al, 1997). Thus, enhancing parent child attachment patterns and communication becomes important. Treatment emphasizes the identification of stimuli that may elicit dissociative responses such as parent-child interaction patterns that are reminiscent of previous traumatic episodes, in which attachment was threatened. Family interventions involve enhancing reciprocity in communication, encouraging direct expression of feeling (Wieland, 1998) and avoiding the reinforcement of regressive coping (Silberg, 2001). The therapist models for the child and family interactive styles that encourage wholeness, responsibility, and tolerance for the expression of feelings.

Treatment Components:

<u>Child</u>

- Identify precursors for transitions in state and learn to self-regulate state transitions.
- Learn direct communication of feelings and self-regulation .
- Promote self-awareness, and self-acceptance of all feelings , behaviors and sensations leading to increased responsibility.
- Highlight differences between "then" and "now" emphasizing current safety in the environment.
- Use imagery, play, or art to self-soothe and provide mastery over traumatic experiences.

Family

- Consistently hold the child responsible for behavior even if perceived as outside of child's control.
- Encourage families to allow expression of affect and acceptance of the whole child.
- Enhance communication encouraging speaking about the trauma and the family's, (previous family's, society's) inability to keep the child safe.
- Avoid reinforcement of regressive coping, or literal view of the child's perception of divided self.

Duration of Treatment: 6 to 24 months

Treatment Manuals or Protocol Descriptions:

International Society for the Study of Dissociation. (2000). Guidelines for the evaluation and treatment of dissociative symptoms in children and adolescents. *Journal of Trauma and Dissociation, 1*(3), 105-154.

Ogawa, J. R., Sroufe, L. A., Weinfield, N. S., Carlson, E. A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology, 9*, 855-879.

Putnam. F. W. (1997). *Dissociation in children and adolescents*. New York: Guilford

Silberg, J. L. (2001). Treating maladaptive dissociation in a young teen-age girl, in H. Orvaschel, J. Faust, & M. Hersen (Eds.), *Handbook of conceptualization and treatment of child psychopathology*. New York: Pergamon Press.

Silberg, J L.(2000). Fifteen Years of Dissociation in Maltreated Children: Where do we go from here? *Child Maltreatment, 5*, 2, 119-136.

Wieland, S. (1998). *Techniques and Issues in abuse-focused therapy*. Thousand Oaks, CA: Sage Publications.

Treatment Outcome Study References:

None

Classification Rating: 4

Intensive Family Preservation Services

Prepared by Charlotte Booth, MSW

Brief Description:

This protocol is a brief, home-based multiple component intervention designed to prevent child out of home placement and reduce risk for child maltreatment by changing behaviors and increasing skills. Treatment components are primarily cognitive-behavioral and matched to identified problem areas.

Theory and Rationale

Families where there has been child abuse or are at high risk often experience problems in functioning that can lead to child placement. Parental skill deficits and psychiatric conditions, child behavior problems, and dysfunctional or violent family relationships contribute to the possibility of family disruption. The HOMEBUILDERS program and similar programs use a cognitive behavioral framework to explain the variety of behavioral dysfunctions. The intervention approach consists of the individualized in-home application of a variety of cognitive behavioral and skill-building strategies that target the specific problems that are identified in the family and that create imminent risk of out-of-home placement. The specific strategies used have extensive empirical support (Ammerman, et. al., 1999; Patterson, et. al., 1982; Wahler and Dumas, 1987; Alexander and Parsons, 1973, 1982; Gorman, Kniskern, & Pinsof, 1986). The program approach has also been used for family reunification following foster care (Fraser, Walton, Lewis, Pecora, & Walton, 1996).

A substantial amount of research has been conducted on IFPS programs including several large randomized trials. Although a large majority of treated cases avoid placement, most studies do not find a statistically significant difference in placement rates, suggesting that many of the families referred for the service were not actually at imminent risk for placement (Fraser, Nelson, & Rivard, 1997). Use of IFPS appears to accelerate family reunification (Fraser, et al, 1996). Overall rates of subsequent child maltreatment tend to be low in treated and untreated groups, and groups usually do not differ following intervention. However, lower rates of subsequent child maltreatment have been found in at least one subgroup (Westat, Inc., Chapin Hall Center for Children, & James Bell Associates, 2001). Results of a recent large scale randomized trial in three states showed that where differences were found on family functioning and child problems, the majority favored the IFPS intervention.

Treatment Components:

- Service provision in the client home
- Engagement and relationship building through Rogerian listening techniques
- Behavioral assessment of client strengths and needs
- Goal-oriented service planning
- Cognitive-behavioral parenting and problem solving techniques
- Life-skills training
- Provision of concrete services (e.g., assistance with housing)
- Building client social support networks

- Motivational Interviewing and relapse prevention strategies for parents with substance abuse problems

Treatment Manuals or Protocol Descriptions:

Kinney, J.M., Haapala, D., and Booth, C.L. (1991). *Keeping Families Together: The Homebuilders Model.* New York: Aldine de Gruyter.

Tracy, E.M., Haapala, D.A., Kinney, J., and Pecora, P.J. (Eds.) (1991). *Intensive Family Preservation Services: An Instructional Sourcebook.* Cleveland, OH: Mandel School of Applied Social Sciences, Case Western Reserve University.

Whittaker, J.K., Kinney, J.M., Tracy, E.M. Booth, C.L. (Eds.) (1990). *Reaching high-risk families: Intensive family preservation in human services.* New York: Aldine de Gruyter.

Duration of Treatment: 3 to 6 months

Treatment Outcome Study References:

Fraser, M.W., Walton, E., Lewis, R.E., Pecora, P., & Walton, W. (1996). An experiment in family reunification: Correlates of outcomes at one-year follow-up. *Children and Youth Services Review, 16,* 335-361.

Pecora, P.J., Fraser, M.W., Bennett, R.B., & Haapala, D.A. (1991) Placement rates of children and families served by intensive family preservation services programs. In M.W. Fraser, P.J. Pecora, & D.A. Haapala. *Families in Crisis: The Impact of Intensive Family Preservation Services.* (pp. 149-180) New York: Aldine de Gruyter.

Schwartz, I.M., AuClaire, P., & Harris, L. (1991). Family preservation services as an alternative to the out of home placement of adolescents: The Hennepin County experience. In K. Wells & D.E. Biegel (Eds.) *Family preservation services: Research and evaluation.* (pp. 33-46). Newbury Park, CA: Sage.

Westat, Inc., Chapin Hall Center, & James Bell Associates (2001) Evaluation of family preservation and reunification programs: Interim report. Washington, DC: DHHS

Classification Rating: 4

Multisystemic Therapy (MST) for Maltreated Children and their Families

Prepared by Cynthia Cupit Swenson, Ph.D. and Scott W. Henggeler, Ph.D.

Brief Description:

Multisystemic Therapy (MST) is a treatment model that targets key factors within the youth's social ecology that relate to problem behavior and provides multiple, comprehensive interventions that have empirical support.

Theory and Rationale:

The theoretical foundation underlying MST is based on causal modeling studies of serious antisocial behavior (Henggeler, 1991) and social-ecological (Bronfenbrenner, 1979) and family systems (Haley, 1976; Minuchin, 1974) theories of behavior. Behavior is viewed as multidetermined and, consequently, problem behavior may be maintained by difficulties within any of the pertinent systems (e.g., family, peer, school, community) in which the youth is involved. Thus, the scope of MST interventions is not limited to an individual youth or the family system, but includes difficulties within and between other systems.

MST was originally developed in the late 1970's to address youth antisocial behavior and has been identified as a highly promising treatment model by reviewers in the fields of substance abuse (e.g., McBride, VanderWaal, Terry, & VanBuren, 1999; National Institute on Drug Abuse, 1999; Stanton & Shadish, 1997), adolescent violence (e.g., Elliott, 1998; Farrington & Welsh, 1999; Tate, Reppucci, & Mulvey, 1995), and mental health (e.g., Kazdin & Weisz, 1998; U.S. Department of Health and Human Services, 1999). Eight randomized clinical trials have been published with youth presenting serious clinical problems and their families, and several others are currently underway. The majority of these trials have been conducted in field settings, and the targeted populations have included inner-city delinquents (Henggeler et al., 1986), three trials with violent and chronic juvenile offenders (Borduin et al., 1995; Henggeler et al., 1997; Henggeler, Melton, & Smith, 1992; Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993), substance abusing or dependent juvenile offenders with high rates of psychiatric comorbidity (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999; Henggeler, Pickrel, & Brondino, 1999; Schoenwald, Ward, Henggeler, Pickrel, & Patel, 1996), youths presenting psychiatric emergencies (i.e., suicidal, homicidal, psychotic) (Henggeler, Rowland et al., 1999; Schoenwald, Ward, Henggeler, & Rowland, 2000), and juvenile sexual offenders (Borduin, Henggeler, Blaske, & Stein, 1990). Results from these studies support the short- and long-term clinical effectiveness of MST as well as its potential to produce significant cost savings and capacity to retain families in treatment. In comparison with control groups, MST has consistently demonstrated improved family relations and family functioning, improved school attendance, decreased adolescent drug use, 25% to 70% decreases in long-term rates of rearrest, and 47% to 64% decreases in long-term rates of days in out-of-home placements.

Given that a large body of literature supports a multidetermined etiology of child maltreatment, comprehensively addressing the factors that may drive maltreatment seems logical. To date one randomized trial has taken on this challenge by evaluating the effectiveness of MST versus parent training with abusive and neglectful families (Brunk, Henggeler, & Whelan, 1987). MST was more effective than Parent Training for improving parent-child

interactions associated with maltreatment. Abusive parents showed greater progress in controlling their child's behavior, maltreated children exhibited less passive noncompliance, and neglecting parents became more responsive to their child's behavior. Parent training was superior to MST on decreasing social problems (i.e., social support network). Although outcomes were promising, no follow-up was conducted. MST is currently being tested specifically with physically abusive families in a randomized trial.

Treatment Components:

- Assessment to understand the "fit" between the identified problems and their broader systemic context. For example fit factors that explain maltreatment may include poor anger management, substance abuse, limited parenting skills.
- With the youth, family, and other people in the youth's ecology, determine overarching goals of treatment.
- Determine systemic strengths and use those as levers for change (e.g., supportive extended family that can help with child monitoring).
- Develop present-focused and action-oriented interventions that have empirical support and target the fit factors (e.g., cognitive behavioral techniques for anger management are taught to the abusive parent and spouse who can help with implementation).
- Implement interventions in the family home or community and at times that are convenient for families.
- Implement interventions that empower the family; that is, interventions that allow families to do for themselves rather than having the therapists do for them.
- Evaluation of intervention efficacy continuously and from multiple perspectives.

Duration of Treatment: 4 to 6 months

Treatment Manuals or Protocol Descriptions:

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents.* New York: Guilford Press.

Treatment Outcome Study References:

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology, 63,* 569-578.

Brunk, M., Henggeler, S. W., & Whelan, J. P. (1987). A comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology, 55,* 311-318.

Henggeler, S. W., Pickrel, S. G., & Brondino, M. J. (1999). Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. *Mental Health Services Research, 1,* 171-184.

Henggeler, S. W., Rowland, M. R., Randall, J., Ward, D., Pickrel, S. G., Cunningham, P. B., Miller, S. L., Edwards, J. E., Zealberg, J., Hand, L., & Santos, A. B. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youth in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*, 1331-1339.

Classification Rating: 3

Parent-Child Education Program for Physically Abusive Parents

Prepared by David Wolfe, Ph.D.

Brief Description:

This protocol is a home- or clinic-based intervention designed to establish positive parent-child interactions and childrearing methods that are responsive to situational and developmental changes and reduce parents' reliance on power-assertive methods that can turn into verbal and physical abuse.

Theory and Rationale:

Child physical abuse occurs most often during periods of stressful role transition for parents, such as the postnatal period of attachment, the early childhood period of increasing socialization pressures, times of family instability and disruption, or following chronic detachment from social supports and services (Wolfe, 1999). This approach is derived from attachment theory, with its emphasis on early relationship formation, and social learning theory's principles of behavioral and cognitive learning. Training parents in effective childrearing methods is based on practical applications of learning principles: educating parents about very basic contingency management principles (e.g., reinforcement, punishment, consistency, etc.); modeling for the parents (via films or live demonstrations) new ways of problem-solving and increasing child compliance; rehearsing the desired skills in non-threatening situations, with increasingly more and more realistic applications (i.e., practicing in the home with the therapist); and providing feedback (verbal or videotaped) to the parents regarding their performance (Becker, Alpert, BigFoot, Bonner, Geddie, Henggeler, Kaufman, & Walker, 1995; Wolfe & Wekerle, 1993). The goals of intervention involve the development of strong positive child-rearing abilities by strengthening the early formation of the parent-child relationship, improvement in the parent's abilities to cope with stress through exposure to a mental health support system, and the development of the child's adaptive behaviors that will contribute to his or her emotional and psychological adjustment. These methods emphasize education and guidance in a format that is flexible and responsive to the needs of families and individuals. Intervention is often re-directed toward important issues that families face during each of the emerging developmental stages that the child and parent must endure. For example, parents who require concrete demonstration of methods to promote child compliance, are socially-isolated, or demonstrate anger control problems are offered individual or group intervention designed to teach skills such as nonviolent discipline methods, self-control, and ways to access community resources.

Treatment Components:

Methods for Enhancing Parental Sensitivity

- Connecting parents to corollary services in the community that provide peer activities, social support, and childcare assistance.
- Having parents watch and follow child's actions, without directing or interfering.
- Teaching parents to speak loudly and clearly, and provide some narrative aloud of the child's ongoing activity.

- Learning to display positive emotion spontaneously while watching and playing with their child.
- Learning to use verbal praise, hugs, and other positive reactions to the child's appropriate behavior.
- Focusing on any special needs of the child during training exercises with parents.
- Teaching child, via parental activities, to extend his/her attention span gradually and develop appropriate forms of communication and expression of positive emotion.

Setting Reasonable Expectations for Children's Emotional and Behavioral Development

- Teaching activities to promote child's language and interpersonal skills development.
- Parental review of their child expectations with therapist, and work at defining and setting appropriate limits and expectations.
- Learning to use verbal guidance and proper commands with child, when attempting to teach child or to limit child's off-task behavior.
- Learning to use unambiguous, appropriate expressions of affect when giving commands, monitoring compliance or activities of the child, and when administering praise and expressing interest.
- Teaching child to attend to tasks and activities for longer periods of time, and begin to display an enthusiasm for learning and playing.
- Teaching child compliance to parental requests, in accordance with their level of development and (modified) parental expectations.
- Strengthen child's developmental weaknesses in communication and social interaction.

Anger Control and Effective Discipline Strategies

- Learning to handle minor frustrations and setbacks with the child, by using humor, distraction, meaningful activities, and simple coping statements.
- Applying basic skills to ongoing problems they have identified with their child.
- Identifying sources of anger and its self-expression, and learning to control arousal prior to disciplining child.
- Understanding the "rules of punishment" and clarifying their expectations for its short- and long-range impact.
- Using non-physical, behavior-focused alternatives to corporal punishment, verbal coercion, or emotional abuse.
- Practice anger control and appropriate discipline while engaging in live, provocative situations with their child.
- Teaching child to respond to non-coercive, non-violent discipline methods without escalating conflict.

Duration of Treatment: 4 to 12 months. Follow-up may occur for 1 to 2 years

Treatment Manuals or Protocol Descriptions:

Wolfe, D. A. (1991). *Preventing physical and emotional abuse of children*. New York: Guilford Press.

Treatment Outcome Study References:

Wolfe, D. A., Sandler, J., & Kaufman, K. (1981). A competency-based parent training program for child abusers. *Journal of Consulting and Clinical Psychology, 49*, 633-640.

Wolfe, D. A., St. Lawrence, J., Graves, K., Brehony, K., Bradlyn, A., & Kelly, J. A. (1982). Intensive behavioral parent training for a child abusive mother. *Behavior Therapy, 13*, 438-451.

Wolfe, D. A., Edwards, B., Manion, I., & Koverola, C. (1988). Early intervention for parents at-risk for child abuse and neglect: A preliminary investigation. *Journal of Consulting and Clinical Psychology, 56*, 40-47.

Classification Rating: 3

Parent-Child Interaction Therapy (PCIT)

Prepared by Anthony Urquiza, Ph.D.

Brief Description:

This intervention is a behavioral and interpersonal dyadic intervention for children (ages 2-8 years) and their parents or caregivers that is focused on decreasing externalized child behavior problems (e.g., defiance, aggression), increasing positive parent behaviors, and improving the quality of the parent-child relationship.

Theory and Rationale:

There are many underlying factors that contribute to the development of physically abusive families. Foremost among these factors is the nature of the parent-child relationship. Abusive parents are characterized by high rates of negative interaction, low rates of positive interaction, and limited and ineffective parental disciplining strategies (Kolko, 1995). At the same time, physically abused children have been reported to be aggressive, defiant, non-compliant, and resistant to parental direction (Kolko, 1995). These patterns of interaction result in a negative and coercive parent-child relationship that may escalate to the point of severe corporal punishment and physical abuse (Urquiza & McNeil, 1996). This pattern eventually can become a relatively stable form of resolving parent-child conflicts that also generates ongoing risk for child maltreatment. While it is likely that there are many different types of physically abusive parent-child relationships, this particular cycle may explain a substantial portion of physical abuse situations, especially those that evolve from routine daily interactions around compliance and discipline. Parent-Child Interaction Training (PCIT) was developed by Sheila Eyberg to address families with negative interactional patterns where the children are oppositional and defiant and has been shown to be effective with these high-risk families (Eyberg, 1988). It is an intervention that is especially appropriate for use in physical abusive situations because it targets the specific deficits often found within physically abusive parent-child dyads that can lead to maltreatment. The approach incorporates both the parent and the child (and other involved family members) in the intervention process. It provides an in vivo opportunity to alter the pattern of interactions within abusive relationships, and it serves as a mechanism to directly decrease negative affect and control - while promoting greater positive affect and discipline strategies. The interventions combine elements of family systems, learning theory and traditional play therapy. The emphasis is on restructuring parent-child patterns, not modifying behaviors (Hembree-Kigin & McNeil, 1995). The therapist takes an extremely active and directive role in the process. The intervention consists of an initial set of approximately six sessions devoted to enhancing positive interactions, and then another six that focus on improving disciplinary practices. Progress is tracked and once parents achieve competence in one area they shift the treatment focus.

Treatment Components:

- Establish a therapeutic alliance and explain treatment process.

Child Directed Interaction

- Parent is taught the elements of the acronym PRIDE (P = praise, R = reflect, I = imitation, D = description, E = enthusiasm).
- Parent is encouraged not to use "No-Don't-Stop-Quit-Not" in interactions with child.
- The parent is instructed to interact/play with the child and to ask the child to clean up for specified periods of time while being observed from behind a one way mirror.
- The parent wears a FM-signal audio reception device (commonly referred as a 'bug-in-the-ear') to listen to directions, prompts, and instructions.
- The PCIT therapist is in an adjoining observation room and observes specific behaviors and interpersonal dynamics, then provides prompts and feedback (i.e., suggestions, praise, correction) to the parent to promote PRIDE and decrease "No-Don't-Stop-Quit-Not".
- Specific behaviors are tracked and charted on a graph at periodic intervals to provide parents with specific information about progress in positive interactions and the achievement of mastery.

Parent Directed Interaction

- Parent is instructed in giving commands and directions.
- Child is given a difficult task that may evoke disobedience/defiance or other behaviors.
- Parent receives coaching through the "bug-in the-ear" to help the child practice minding.
- Parent is instructed in ways to generalize the skills to siblings, and "problem times".

Duration of Treatment:

6 sessions devoted to relationship enhancement; 6 sessions on disciplinary practices

Treatment Manuals or Protocol Descriptions:

Hembree-Kigin, T., & McNeil, C.B. (1995). *Parent-Child Interaction Therapy*. New York: Plenum.

Urquiza, A.J., Zebell, N., McGrath, J., & Vargas, E. (1999). *Parent-Child Interaction Therapy: Application to high-risk and maltreating families*. Unpublished treatment manual. Author. Child Protection Center, Department of Pediatrics, University of California Davis Medical Center, 3300 Satockton Blvd., Sacremento, CA 95820

Urquiza, A.J., Zebell, N., McGrath, J., & Vargas, E. (1999). *Parent-Child Interaction Therapy: Application to high-risk and maltreating families*. Videotape series. Author. Child Protection Center, Department of Pediatrics, University of California Davis Medical Center, 3300 Satockton Blvd., Sacremento, CA 95820

Urquiza, A.J., & McNeil, C.B. (1996). Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment, 1*(2), 132-141.

Treatment Outcome Study References:

Borrego, J., & Urquiza, A.J. (1998). Importance of therapist use of social reinforcement with parents as a model for parent-child relationships: An example with Parent-Child Interaction Therapy. *Child and Family Behavior Therapy, 20*(4), 27-54.

Borrego, Jr., J., Urquiza, A.J., Rasmussen, R.A., & Zebell, N. (1999). Parent-Child Interaction Therapy with a Family at High-Risk for Physical Abuse. *Child Maltreatment, 4*(4), 331-342.

Eyberg, S.M. (1988). Parent-child interaction therapy: Integration of traditional and behavioral concerns. *Child and Family Behavior Therapy, 10,* 33-46.

Eyberg, S., & Robinson, E.A. (1982). Parent-child interaction training: Effects on family functioning. *Journal of Clinical Child Psychology, 11*, 130-137.

Classification Rating: 3

Physical Abuse-informed Family Therapy

Prepared by David Kolko, Ph.D.

Brief Description:

This treatment approach is a family systems intervention for children and physically abusive parents that seeks to reduce violence and improve child outcomes by promoting cooperation, developing shared views about the value of non-coercive interactions, and increasing skills of family members

Theory and Rationale:

The family-ecological model views child physical abuse from a systemic perspective emphasizing the interrelationships among individual, family, and social support factors (e.g., family communication, extra familial contacts; Belsky, 1993). Treatment seeks to address various child (e.g., feelings), parent (e.g., poor empathy, physical punishment) and/or family issues (e.g., role reversal). Most interventions involving family therapy (FT) or multiple services directed toward the family system have not been formally evaluated (see Wolfe & Wekerle, 1993). Family-centered services have been associated with improvements in child developmental status, parenting skill, and family relationships (Brunk, Henggeler, & Whelan, 1987; Culp, Little, Letts, & Lawrence, 1991; Nicol, Smith, Kay, Hall, Barlow, & Williams, 1988). However, such outcomes are qualified by the absence of follow-up data (Brunk et al., 1987), high attrition (Nichol et al., 1988), and the limited maintenance of treatment effects (Lutzker, 1990). Abuse-informed FT is designed to enhance family functioning and relationships (Alexander & Parsons, 1982; Robin & Foster, 1989), in accord with the interactional or ecological model approach to child maltreatment (Belsky, 1993). Treatment seeks to enhance the cooperation and motivation of all family members by promoting an understanding of coercive behavior, teaching the family positive communication skills and how to solve problems together. The treatment has been shown to be superior to routine community service in reducing violence and improving child outcomes (Kolko, 1996c).

Treatment Components:

Engagement phase

- Assessment of the family's structural roles and interactions (e.g., genogram).
- Reframing to enhance cooperation among family members (Alexander & Parsons, 1982; Szapocnik & Kurtines, 1989).
- Discussion of the negative effects of the use of physical force.
- Agreement to a no-violence contract by all family members (Anderson & Reiss, 1983).

Skill-building phase

- Training to use specific problem solving and communication skills at home (Robin & Foster, 1989).

Application/termination phase

- Establishing problem-solving family routines as alternatives to coercion or physical punishment (Szapocnik & Kurtines, 1989).

Duration of Treatment: 12 to 24 sessions

Treatment Manuals or Protocol Descriptions:

Kolko, D.J., & Swenson, C.C. (2002). *Assessing and treating physically abused children and their families: A cognitive-behavioral approach.* Thousand Oaks, CA: Sage Publications.

Swenson, C.C. & Kolko, D.J. (2000). Long-term management of the developmental consequences of child physical abuse. In R. Reece (ed.). *The treatment of child abuse.* Baltimore, MD: Johns Hopkins University Press.

Treatment Outcome Study References:

Kolko, D.J. (1996) Individual cognitive behavioral therapy and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1*, 322-342.

Classification Rating: 3

Parents United
(Child Sexual Abuse Treatment Program)

Prepared by Debra A. Johnson, Ph.D.

Brief Description:

Parents United is a clinically based, integrated treatment program which provides direct clinical services as well as a variety of non-clinical support for victims, offenders, adults molested as children, and their support persons. The clinical services are provided by the clinical sponsoring agency for the Parents United chapter and the non-clinical support services are provided by the Parents United membership itself.

Theory and Rationale:

Parents United is based on the idea that all individuals affected by sexual abuse will benefit from a variety of supportive, adjunctive services in addition to formal clinical interventions. The services include immediate access to information and a supportive response from others who have had similar experiences, as well as concrete assistance with some of the impacts following discovery of abuse. Groups targeted for various sub-populations, including adults molested as children, offenders, denying offenders, offenders who are also victims, parents of abused children and teenage child victims and their offenders, provide a place of mutual recovery, allow participants to address and listen to each other, and serve as a vehicle for developing insight, empathy and understanding. Support persons are also included to enhance the available support system for the involved individuals. Variations on psychoeducation, support, enhancement of interpersonal skills, and cognitive behavioral techniques are used. Some of the groups are progressive; clients move from one to the other as they achieve certain goals. Others are specific to a particular purpose. Most groups meet once a week for eight weeks. In addition, Parents United serves the community at large through a speaker's bureau. Participants create awareness and understanding through sharing their experiences.

Parents United is a nonprofit, membership driven organization which provides most nonclinical support functions for the program. These functions include child care, attendance records, speakers bureaus, support person registry, literature on the program, orientation of membership, etc. Each Parents United Chapter has a clinical sponsoring agency responsible for all treatment services. In the Stanislaus County, California chapter, this agency is Child Sexual Abuse Treatment Services, a for profit agency. This agency provides licensed or license-eligible clinicians and psychologists to lead groups. The theoretical orientation of this program is largely cognitive-behavioral, with relapse prevention being the predominant methodology for offender treatment.

Treatment Components:

Non-clinical Supports

- Information/referral line
- Member Support Services
- Child care
- Supervised child visitation

- Speakers bureau

Clinical Supports
- Program Orientation Group (adults molested as children, offenders, parents of victims, support persons).
- Newcomers Group (adults molested as children, offenders, parents of victims, support persons).
- Psychoeducation about abuse impact on victims/need for support.
- Confrontation/accountability.
- Explanation of treatment process/expectations .

Adults Molested as Children Groups
- To relieve the adult of all feelings of responsibility for childhood victimization
- To empower change and emphasize that each individual has the power to effectively change and successfully manage his/her life
- To expand behavioral options which enable a self fulfilling lifestyle and relationships
- Learn to trust again
- Deal and resolve all feelings associated with the trauma
- Establish self-affirming relationship with non-offending family members

Offender Groups
- Eliminate denial
- Increase personal responsibility-taking for offenders
- Expose/address cognitive behavioral deficits/dysfunctions that precipitate offending
- Increase self-management skills
- Identify the self-destructive impact of abusing
- Label/articulate feelings, cognition, behaviors
- Identify needs in relationship/learn difference between intimacy and manipulation, control and sexualization in relationships
- Learn skills for building healthy adult relationships
- Develop a personal risk assessment/prevention plan to reduce risk of future offending
- Identify/acknowledge childhood abuse experiences

Victim/Offender Group (offenders who are also victims)
- Discuss childhood abuse experience
- Assign full responsibility to offender
- Label/express abuse-related feelings
- Identify how abuse-related feelings interfere with achieving current goals
- Re-evaluate/restructure personal relationships
- Increase self management skills

Recontact Group (offenders, adults molested as children, support persons)
- Acknowledge, label, and articulate personal feelings, cognition and behaviors
- Identify what is missing and what is wanted in trust/interpersonal relationships
- Acknowledge the difference between intimacy and the manipulation, control, and sexualization of others
- Accept responsibility for building appropriate adult relationships

- Learn the skills required to build appropriate adult relationships
- Practice empathy and social awareness when interacting with others
- Verbalize, increase understanding and value of the self and others
- Develop a personal risk assessment/prevention plan that establishes when, how, and where to access help to decrease the risk of future molests
- Stress management
- Active listening
- Acceptance of intra-personal change
- Empathic, intimate relationship skills
- Goal planning

Parent Group (parents of child victims)
- Information/help with access to resources
- Ventilate feelings about abuse
- Discuss the child=s abuse experience
- Psychoeducation about abuse dynamics/impact
- Improve parenting skills

Shared Perceptions Group (adults molested as children, child victims > 12 years, offenders, parents, and support persons)
- Tot's Group (ages 2 through 5)
- Resolve feelings about abuse
- Learn appropriate assertive skills

Children's Group I (ages 6 through 8)
- Resolve feelings about abuse
- Learn appropriate assertive skills

Children's Group II (ages 9 through 12)
- Resolve feelings about abuse
- Learn appropriate assertive skills

Violation of Rights Group
- Eliminate denial
- Increase personal responsibility-taking for offenders
- Expose/address cognitive behavioral deficits/dysfunctions that precipitate offending
- Increase self-management skills
- Identify the self-destructive impact of abusing
- Label/articulate feelings, cognition, behaviors
- Identify needs in relationship/learn difference between intimacy and manipulation, control and sexualization in relationships
- Learn skills for building healthy adult relationships
- Develop a personal risk assessment/prevention plan to reduce risk of future offending
- Identify/acknowledge childhood abuse experiences

Teen Offenders Group

- Eliminate denial
- Increase personal responsibility-taking for offenders
- Expose/address cognitive behavioral deficits/dysfunctions that precipitate offending
- Increase self-management skills
- Identify the self-destructive impact of abusing
- Label/articulate feelings, cognition, behaviors
- Identify needs in relationship/learn difference between intimacy and manipulation, control and sexualization in relationships
- Learn skills for building healthy adult relationships
- Develop a personal risk assessment/prevention plan to reduce risk of future offending
- Identify/acknowledge childhood abuse experiences

Teen Male Victim Group

- Resolve feelings about molest
- Learn appropriate assertive skills
- Learn skills for building healthy relationships

High School Girls Group

- Resolve feelings about molest
- Learn appropriate assertive skills
- Learn skills for building healthy relationships

Junior High School Girls Group

- Resolve feelings about molest
- Learn appropriate assertive skills
- Learn skills for building healthy relationships

Duration of Treatment: typically 8 weeks for each group, open-ended for total program

Treatment Manuals or Protocol Descriptions:

Child Sexual Abuse Treatment Services. (1994). *Treatment Manual for Child Sexual Abuse Treatment Services*. Modesto, CA: Author.

Giarretto, H., & Einfeld-Giarretto, A. (undated). *Integrated Treatment: The Self-Help Factor- L-10*. Giarretto Institute, Training Department- Literature Order, 232 East Gish Road, San Jose, California 95112.

Treatment Outcome Study References:

Abbott, B. (undated). Sexual Re-offense Rate Among Incest Offenders 8 Years After Leaving Treatment- L-15. Giarretto Institute, Training Department- Literature Order, 232 East Gish Road, San Jose, California 95112.

Classification Rating: 4

Parents Anonymous®

Prepared by Rochelle F. Hanson, Ph.D. and Sheri Rosen

Brief Description:

Parents Anonymous, Inc. is an organization designed to strengthen at-risk and abusive parents or adults in parenting roles through mutual support, shared leadership and personal growth. The ongoing, open-ended groups offer the opportunity to learn new skills, transform attitudes and behaviors, and create lasting change.

Theory and Rationale

Parents Anonymous® is based on the idea that through participation in groups parents learn to identify and build on their strengths, increase their ability to deal with stress, expand their social support networks, and develop realistic expectations of themselves and their children. Parents are encouraged to take responsibility for their own problems and give and get support from one another to find solutions. Parents Anonymous® groups provide support, a safe and caring environment, encouragement to parents for taking charge of their lives and their families, and opportunities for attitude change and the integration of new knowledge and skills. Providing opportunities to develop friendships reduces isolation. The three essential components needed to create long-term behavioral change are the opportunity to: (1) examine attitudes and childrearing practices and learn new skills and behaviors, (2) practice newly learned skills and behaviors within the safety of the group and at home, and (3) incorporate the new skill or behavior into their daily life.

Parents Anonymous® encourages parents to ask for help early, whatever their circumstances, in order to effectively break the cycle of abuse and strengthen their families. Weekly, Parents Anonymous® groups are co-led by parents and professionally trained facilitators and are free of charge to participants. Parents or adults in parenting roles (e.g., grandparents, aunts, uncles, foster parents, stepparents, or older siblings) who are concerned about their parenting abilities and seeking support, information and training are welcome at Parents Anonymous® groups, whatever the age of their children or their current circumstances. Parents Anonymous® groups are ongoing and open ended; parents can join at any time and participate as long as they wish. Group participation is not restricted by age, education level, income, problems experienced by the parent or children, or any other specific criteria. Because the groups are community based, participants mirror the ethnic, geographical, and cultural nature of their neighborhoods.

Treatment Components:

Parents Anonymous® Groups

- Opportunity to discuss difficulties in child rearing (e g., parental roles, methods for dealing with stresses of parenting).
- Information about child rearing (e.g., child development, alternative discipline, getting children to cooperate, strategies to help children achieve independence and self-control).
- A network of other parents to assist with baby-sitting, phone support, and caring
- Information about positive parenting

Additional Services

- Parents Anonymous® Children's Program runs in conjunction with Parents Anonymous® groups
- Informational seminars and workshops on a variety of subjects
- Parent topic workshops
- Resource and referral access
- 24-hour toll-free information and referral Helpline at the state and local levels

Duration of Treatment: open-ended

Treatment Manuals or Protocol Descriptions:

Lieber, L., & Baker, J.M. (1977). Parents Anonymous® – Self-help treatment for child abusing parents: A review and evaluation. *Child Abuse & Neglect, 1*, 133-148.

Rafael, T., & Pion-Berlin, L. (1999). *Parents Anonymous®: Strengthening Families*. OJJDP Family Strengthening Bulletin No. NCJ171120. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Rafael, T., & Pion-Berlin, L. (1996). *Parents Anonymous, Inc. Program Bulletin*. Claremont, CA: Author.

Treatment Outcome Research Studies:

Pion-Berlin, L., & Polinsky, M.L. (2000). *Research Profile No. 1*. Claremont, CA: Parents Anonymous, Inc.

Classification Rating: 4

Offender Interventions

Adolescent Sex Offender Treatment

Prepared by Mark Chaffin, Ph.D.

Brief Description:

Adolescent sex offender treatment is an intervention most often carried out in a specialized program and usually containing a variety of cognitive behavioral techniques that are designed to change offense supportive beliefs and attributions, improve handling of negative emotions, teach behavioral risk management, and promote prosocial behavior.

Theory and Rationale:

A variety of treatment approaches have been used with youth that have committed sexual offenses. These include general and non-specific mental health treatments (e.g. individual psychotherapy, family therapy, inpatient milieu therapy), delinquency focused treatments (e.g. standard Multi-Systemic Therapy (MST), boot camps, juvenile group homes) as well as programs designed specifically for, and limited to, adolescent sex offenders (e.g. cognitive behavioral sex offender group therapy, relapse prevention, arousal reprogramming techniques). Many of these adolescent sex-offender specific programs have been based upon models used in treating adult sex offenders. However, it should be recognized that adolescent sex offenders, as a group, are different than their adult counterparts, and generally do not present the same kinds or levels of sexual deviancy and psychopathic tendencies sometimes seen among adult sex offenders (Association for the Treatment of Sexual Abusers, 1997).

At this time, there is no clear scientific evidence to favor any particular treatment approach, or even to demonstrate that adolescent sexual offender treatment is effective at all. Nonetheless, it does appear that short to moderate term detected sexual recidivism rates are not high after any type of treatment. Detected sexual recidivism averages under 10% across a variety of treatment approaches, follow-up times, and recidivism measures (Alexander, 1999). Most outcome studies report far higher rates of non-sexual than sexual recidivism in this population, suggesting that it is important to focus on broad behavioral goals rather than exclusively on sexual behavior. Although the scientific outcome literature is limited, there are commonly employed and accepted clinical practices. Many adolescent sexual offenders are seen in specialized offender-specific programs that include peer group therapy and use some variety of cognitive behavioral approach (Burton, et al. 1996, National Task Force, 1993). There also is evidence to favor the MST approach (see Swenson, et al. 1998). It is generally agreed that involving families and significant others in treatment is beneficial.

Treatment Components:

Core treatment modules

- Psychoeducation about the consequences of abusive behavior
- Increasing victim empathy
- Identifying personal risk factors
- Promoting healthy sexual attitudes and beliefs
- Social skills training
- Sex education

- Anger management
- Relapse prevention.

Case-specific treatment components
- Addressing personal history of sexual victimization
- Behavioral techniques or medication designed to modify deviant sexual arousal

Parent components
- Engendering support for treatment and behavior change
- Encouraging supervision and monitoring
- Teaching recognition of risk signs
- Promoting guidance and support to their teenager.

Duration of Treatment: 30-75 outpatient sessions

Treatment Manual and Protocol Descriptions:

Henggeler, S.W., Swenson, C.C., Kaufman, K., & Schoenwald, S.K. (1997). *MST Supplementary Treatment Manual For Juvenile Sexual Offenders And Their Families*, Provided to the Institute for Families in Society, University of South Carolina by the Family Services Research Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina.

Kahn, T.J. (1996). *Pathways: A Guided Workbook for Youth Beginning Treatment.* Orwell, VT: Safer Society Press.

Kahn, T.J. (1996). *Pathways Guide for Parents of Youth Beginning Treatment.* Orwell, VT: Safer Society Press.

Marsh, L.F., Connell, P., & Olson, E. (1988). *Breaking the Cycle: Adolescent Sexual Treatment Manual.* Available from St. Mary's Home for Boys, 16535 SW Tualatin Valley Highway, Beaverton, OR 97006.

O'Brien, M.J. (1994). *PHASE Treatment Manual.* Available from Alpha PHASE, Inc., 1600 University Ave., West, Suite 305. St. Paul, MN. 55104-3825.

Steen, C. (1993). *The Relapse Prevention Workbook for Youth In Treatment.* Orwell, VT: Safer Society Press.

Way, I.F., & Balthazor, T.J. (1990). *A Manual for Structured Group Treatment with Adolescent Sexual Offenders.* Notre Dame, IN: Jalice.

Treatment Outcome Study References:

Borduin, C.M., Henggeler, S.W., Blaske, D.M., & Stein, R.J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy & Comparative Criminology, 34*, 105-113.

Classification Rating: 3

Adult Child Molester Treatment

Prepared by Donya L. Adkerson, M.A., L.C.P.C.

Brief Description:

Adult child molester treatment uses cognitive behavioral and adjunctive therapies to help child sexual offenders develop the motivation and skills to stop sexual offending by replacing harmful thinking and behaviors with healthy thoughts and the skills to make choices that will reduce risk. Specialized treatment typically includes individual or group therapy with additional intervention through education of, and monitoring by, collaterals in offenders' environment.

Theory and Rationale:

Sexual molestation of children is a treatable though not curable behavior problem, and most offenders require external motivators to successfully complete the treatment process (Association for the Treatment of Sexual Abusers, 2001). Sexual child abusers are a heterogenous group who may have a variety of psychological and behavioral problems or show no psychopathology beyond their sexual interest in a particular child (Salter, 1995). The problem may involve sexually deviant sexual interests in pre-pubertal children or the unwillingness to abide by social expectations and laws prohibiting sexual relationships with under-age adolescents. Many child molesters have committed additional types of sexual offenses, and intrafamilial offenders may well have extrafamilial victims (Abel et al., 1988; Salter, 1995). Child molesters with male victims show higher recidivism rates than those with only female victims (Alexander, 1999; Hanson, 1997; Maletzky, 1993). While multiple etiological pathways to sexual offending are probable, effective intervention focuses on modifying those factors that support the desire, capacity, and opportunity to offend. Cognitive behavioral approaches are currently considered the most effective methods of treatment, with pharmacological, educational, skills-building, self-help, and other methods used as adjuncts to treatment (Association for the Treatment of Sexual Abusers, 2001). An analysis of 79 treatment studies found that treatment of child molesters by Relapse Prevention and other cognitive behavioral approaches brought known recidivism rates to 8.1%, compared to 18.3% for other treatment approaches and 25.8% for untreated molesters (Alexander, 1999). The presence of sexual deviancy and psychopathy substantially increases the risk of recidivism. There is currently no known effective treatment for psychopathy.

The desire to be sexual with a child is generally rooted in deviant sexual arousal patterns and/or inadequate competency in meeting psychosocial and sexual needs in consensual adult relationships. Dysfunctional core beliefs and ongoing distorted thinking are used by the offender to justify and facilitate the sexual offense behavior. Some offenders turn to sexual fantasy and offending in response to specific disinhibitors, such as negative affective states, while others actively approach offending as an ego-syntonic goal (Ward, Hudson, & Keenan, 1998). Psychophysiological assessment techniques (e.g., plethysmography, polygraph) are useful, as most offenders enter treatment demonstrating denial and minimization of part or all of their offense history and arousal patterns. Such client denial complicates both accurate initial assessment and ongoing evaluation of treatment progress. Therapy that addresses the specific elements of the offender's beliefs and feelings that lead to sexual offending behaviors and

includes an individualized relapse prevention component is currently considered the approach most likely to decrease new sexual offenses.

Treatment Components:

Core Therapeutic Tasks

- Implement environmental changes to reduce opportunity for sexual offense
- Develop personal accountability for the complete sexual offense history
- Modification and management of deviant arousal patterns
- Identify and correct dysfunctional core beliefs and faulty cognitions
- Identification of offense cycle (all factors--emotional, perceptual, cognitive, behavioral--that increase personal risk for sexual offending)
- Develop and implement practical strategies to interrupt the offense cycle and replace past responses with healthy behaviors
- Understand the extent of harm to victims from sexual offending and increase motivation to refrain from harming others

Adjunctive Therapeutic Tasks, as needed

- Social/sexual education and skills building
- Education and support for collaterals who support and monitor the offender
- Intervention for concurrent problem areas (e.g., substance abuse, anger management)
- Trauma resolution
- Relationship therapy
- Reunification therapy (This should be undertaken ONLY if/when the offender has made significant gains in treatment, is showing full accountability, demonstrates ability to manage deviant arousal; the non-offending parent is appropriately trained and motivated to protect the children both physically and emotionally; AND reunification work is in the best interest of the children.)

Duration of Treatment: 1-2 years of active treatment; weekly individual and/or group sessions

Treatment Manuals or Protocol Descriptions:

Association for the Treatment of Sexual Abusers. (2001). *Practice Standards and Guidelines for Members of the Association for the Treatment of Sexual Abusers.* Beaverton, OR: Author.

Abel, G.G., Becker, J.V., Cunningham-Rathner, J., Rouleau, J.L., Kaplan, M., & Reich, J. (undated). *The treatment of child molesters.* Atlanta, GA: Author.

Bays, L., & Freeman-Longo, R. (1989). *Why did I do it again? Understanding my cycle of problem behaviors.* Holyoake, MA: NEARI Press.

Bays, L., Freeman-Longo, R., & Hildebran, D.D. (1990). *How can I stop? Breaking my deviant cycle.* Holyoake, MA: NEARI Press.

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Barbaree, H.E., & Seto, M.C. (1997). Pedophilia: Assessment and treatment. In D.R. Laws and W. O'Donohue (Eds.), *Sexual Deviance: Theory, Assessment, and Treatment* (pp. 175-193). New York: Guilford.

Freeman-Longo, R., & Bays, L. (1988). *Who am I and why am I in treatment?*. Holyoake, MA: NEARI Press.

Salter, A.C. (1988). *Treating Child Sex Offenders and Victims.* Thousand Oaks, CA: Sage Publications.

Treatment Outcome Study References:

Alexander, M.A. (1999). Sexual offender treatment efficacy revisited. *Sexual Abuse: A Journal of Research and Treatment, 11*(2), 101-116.

Dwyer, S.M. (1997). Treatment outcome study: Seventeen years after sexual offender treatment. *Sexual Abuse: A Journal of Research and Treatment, 9*(2), 149-160.

Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V. L., & Seto, M.C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 169-194.

Hanson, R.K., Steffy, R.A., & Gauthier, R. (1992). *Long-term follow-up of child molesters: Risk prediction and treatment outcome.* (User Report No. 1992-02.) Ottawa: Corrections Branch, Ministry of the Solicitor General of Canada.

Classification Rating: 2

Summary of Treatment Protocols

Table 1 presents a summary of the 24 treatment protocols reviewed and their classifications on the factors assessed. Concerning their theoretical basis, eight were judged to have employed a somewhat novel, but reasonable approach to the use of psychological principles. The theoretical foundation of one protocol was considered questionable and unacceptable. All other protocols were rated as having a sound theoretical basis in generally accepted psychological principles. Regarding the quantity and quality of the clinical/anecdotal literature describing the use of the protocol, five were assessed as having relatively little literature available about their use with abused children and their families, and eight were rated as having "Some" clinical literature that could be examined. The other protocols have substantial clinical literatures describing their use with abused children and their families. As for acceptance and use within the child abuse treatment community, nine protocols were judged as having "Some use," while five had only limited use. The other 10 protocols were rated as having wide acceptance by practitioners working with child abuse victims and their families.

The potential risk for harm vs. the potential benefits of the treatment were an important factor considered by the National Advisory Committee. Unlike psychopharmacological treatments, the risks of psychotherapy are rarely discussed. However, all therapies carry a potential for harm, and this possibility needs to be recognized and balanced against the potential benefit of the treatment. Therefore, a careful evaluation of the potential for harm vs. the likely benefit of a treatment is critical when determining its utility and acceptability for use in the field. Of the 24 treatments, most were judged to have little risk in their implementation. Six were assessed as carrying some risk, but the level of risk was acceptable given the potential benefits of the treatment. Several of the protocols viewed as having some risk involve the treatment of abusing parents, or are protocols for deciding if and implementing how abusing parents should have contact with their child victims. By their nature, these interventions involve a degree of risk since they involve treating parents who have been physically or sexually violent. However, they are rated as acceptable because the core purpose of the treatment is to reduce the violence potential of parents, thereby reducing risk to children. Presumably, children will benefit by maintaining the parent-child relationship in some form. In these cases, the benefits of the interventions were judged to outweigh their risks.

Table 1. Summary of Treatment Protocol Classifications

Treatment Protocol	Theoretical Basis	Clinical-Anecdotal Literature	Acceptance/ Use in Clinical Practice	Potential for Harm Risk/Benefit Ratio	Empirical Support
CHILD-FOCUSED INTERVENTIONS					
CBT/Psychodynamic Children with Sexual Behavior Problems	CBT-Sound Dynamic-Novel	Substantial Little	Accepted Limited use	Little Risk Some Risk	3
Cognitive Processing Therapy (CPT)	Sound	Substantial	Accepted	Little Risk	3
Eye Movement Desensitization and Reprocessing (EMDR)	Novel/ Reasonable	Substantial	Some Use	Little Risk	3
Child/Parent Physical Abuse CBT	Sound	Substantial	Accepted	Little Risk	3
Resilient Peer Training Intervention	Sound	Little	Limited use	Little Risk	3
Therapeutic Child Development Program	Sound	Substantial	Accepted	Little Risk	3
Trauma-Focused CBT	Sound	Substantial	Accepted	Little Risk	1
Trauma-Focused Integrative-Eclectic Therapy	Sound	Substantial	Accepted	Little Risk	3
Trauma-Focused Play Therapy	Sound	Substantial	Accepted	Little Risk	4
FAMILY, PARENT-CHILD, PARENT-FOCUSED INTERVENTIONS					
Attachment-Trauma Therapy	Novel/ Reasonable	Some	Accepted	Little Risk	4
Behavioral Parent Training	Sound	Some	Some use	Little Risk	3
Corrective Attachment Therapy	Questionable	Little	Limited use	Substantial Risk	6
Family Focused, Child Centered Treatment	Novel/ Reasonable	Some	Some use	Some Risk	3
Family Resolution Therapy	Novel/ Reasonable	Some	Some use	Some Risk	4
Treatment of Dissociative Symptomatology	Novel/ Reasonable	Some	Some use	Little Risk	4
Intensive Family Preservation	Sound	Substantial	Accepted	Little Risk	4

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Multisystemic Therapy (MST)	Sound	Little with child abuse	Limited use with child abuse	Little Risk	3
Parent-Child Education/Physical Abuse	Sound	Substantial	Some use	Little Risk	3
Parent-Child Interaction Therapy	Sound	Some	Some use	Little Risk	3
Physical Abuse Family Therapy	Sound	Little	Limited use	Little Risk	3
Parents United	Novel/ Reasonable	Some	Some use	Some Risk	4
Parents Anonymous	Novel/ Reasonable	Some	Some use	Some Risk	4
OFFENDER INTERVENTIONS					
Adolescent Sex Offender Therapy	Sound	Substantial	Accepted	Some Risk	3
Adult Child Molester Therapy	Sound	Substantial	Accepted	Some Risk	2

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The empirical support for each of the 24 protocols reviewed were categorized according to the classification system described above. The results are described below:

Classification		Number
1.	Well-supported, efficacious treatment	1
2.	Supported and probably efficacious treatment	1
3.	Supported and acceptable treatment	14
4.	Promising and acceptable treatment	7
5.	Innovative or novel treatment	0
6.	Concerning treatment	1
		24

Of the 24 treatments reviewed, 16 had at least some empirical support for their efficacy with cases of child abuse. However, only one, Trauma Focused Cognitive-Behavioral Therapy, met the standards of the highest category, and only one, Adult Child Molester Therapy, was rated in the second highest category. Of the 14 having at least some empirical support (category 3), several have very strong empirical support when used with other client populations, but have not been tested specifically with child abuse victims or their families. However, many of these have been used clinically with abuse victims with positive results. These include well-known treatments such as Behavioral Parent Training, Cognitive Processing Therapy, Multisystemic Therapy (MST) and Eye-Movement Desensitization and Reprocessing (EMDR). Therefore, results of this review show that there are a substantial number of empirically supported treatments available to practitioners working with child victims of abuse and their families. Empirically supported treatments are available for use with problems experienced by child victims, with problems in parent-child relationships, and with abusive parents. These treatments should be considered first choice treatments when working with child victims and their families who have problems targeted by these protocols, and they are recommended for use.

It should be noted that even for these empirically supported treatments, the level of support enjoyed by all but a few is rather thin. Many have only one uncontrolled outcome study backing their efficacy (e.g., Trauma-Focused Integrative-Eclectic Therapy). Some have multiple randomized controlled trials supporting their utility with other populations and are clearly efficacious treatments (e.g., Behavioral Parent Training). But, they have not been tested specifically with abused children and their families. To date, none has undergone a true effectiveness trial with child abuse victims and their families, though admittedly, such trials are relatively rare in all aspects of mental health treatment. Therefore, much clinical outcome research remains to be done to test further the efficacy and effectiveness of all of these treatments with children who have been abused and their families.

Practitioners should note that several well-known and commonly used treatments have no empirical support for their efficacy. For example, Trauma-focused Play Therapy is often used with young victims of abuse. It was judged to have a strong theoretical base, have an excellent

clinical literature, carry little risk, and be widely accepted within the field. Yet, it has no empirical evidence to support its claimed therapeutic effects. Therapies such as this one are prime candidates for future research testing their efficacy. Many of these theoretically sound and widely used therapies may be helpful to clients as indicated by the clinical/anecdotal literature. However, the burden is on the developers and proponents of these treatments to provide empirical evidence of their effects before they can be recommended with more confidence.

One protocol, Corrective Attachment Therapy, was rated as having a "Substantial" and unacceptable level of risk and was rated 6, Concerning. This judgment was made for several reasons. First, it was assessed as having a questionable theoretical basis. Recent literature has suggested that this treatment is a misuse and misapplication of theories of child development and childhood interpersonal attachment processes (Speltz, 2002). Second, the techniques and procedures associated with this protocol were judged to be excessively coercive. Because of the coercive nature of the treatment, the protocol was judged to carry a significant risk for causing psychological and physical harm to children. Third, because of the nature of the procedures used, the treatment was evaluated as having great potential for misuse and misapplication. Fourth, this protocol has a very rare distinction among psychotherapies in that deaths of children receiving this treatment have been reported (Crowler & Love, 2000). These deaths reinforce concerns about the safety of children receiving this intervention. One small (N = 23) outcome study has suggested pre- to post-treatment improvement on parent-rated aggression and delinquency behaviors by children receiving "Holding Therapy" (Myeroff, Mertlich, & Gross, 1999). Despite this finding, any benefits of this treatment that would outweigh its considerable risks are not clear. Therefore, given the significant risk for negative consequences to children, even death, and the lack of convincing evidence of its therapeutic benefit, Corrective Attachment Therapy was determined to constitute a substantial and unacceptable risk of harm to child victims and their families. Therefore, this treatment cannot be recommended, and its use is discouraged.

The results above reveal that practitioners working with child abuse victims and their families have several empirically supported treatments available to them that target common problems in the individual and parent/family domains. If an empirically supported treatment exists for a target problem, clinically accepted but unsupported treatments should be viewed as alternative or second-choice therapies. Decisions to use alternative therapies in the place of first choice treatments should be made carefully, with due consideration to all of the issues involved in such a decision. Practitioners considering using alternative rather than first choice therapies should make such decisions cautiously, and consider seeking consultation from knowledgeable peers. When empirically supported treatments are not available, practitioners should use theoretically sound and widely accepted treatments that have an acceptable level of risk. Concerning treatments, those with few proven benefits and substantial risk, should be avoided.

GENERAL PRINCIPLES FOR TREATMENT OF PHYSICAL AND SEXUAL ABUSE

Principles of Empirically Supported Treatments

Child victims of physical or sexual abuse very often have complicated histories of multiple victimization and trauma, and exhibit a variety of disorders, problems, and difficulties that may or may not be the direct result of abuse (Saunders, in press). Complex histories and multiproblem presentations are considerable assessment and treatment challenges for practitioners. How should children with multiple problems be treated? Should several treatment protocols be employed, one for each problem? What about child victims of both sexual and physical abuse who may have histories of other traumas as well? Should treatments be combined, delivered concurrently, or staged sequentially? It may be helpful for practitioners confronted with these difficult children to use approaches that are shared across empirically supported treatments. The shared theoretical perspectives, treatment procedures, and clinical skills associated with these protocols can be flexibly applied depending on the history, problem matrix, and circumstances of these complex cases.

As presented above, many treatments have been developed for the disorders, conditions, and problems commonly seen in child victims of physical and sexual abuse and their families. Generally, the interventions with the most empirical support tend to be based on behavioral or cognitive behavioral theoretical approaches, utilize behavioral and cognitive intervention procedures and techniques, and intervene at both the individual child and parent/family levels. Many of them share specific treatment procedures and techniques (e.g., cognitive restructuring, exposure procedures, behavioral management skills) that are simply applied to different problems. When examined with complex case presentations in mind, empirically supported protocols have certain common principles and treatment components that can be applied to many different problems children and families may have. Therefore, it is important to identify the common principles and components shared by empirically supported treatment protocols.

In general, treatments with empirical support are goal directed. They are designed to address specific, measurable problems identified through systematic assessment of children and their families. Problems are defined and identified such that they can be measured using sound and accepted assessment tools. Once the problems are defined and measured, a treatment plan can be developed for reducing them, and the effect of the treatment can be assessed over time.

Empirically supported treatments tend to be structured in their approach. They have specific procedures and techniques that are used in order to reduce the problems assessed. Little time is devoted to non-goal directed activity other than for the purpose of rapport building and engaging the client in the therapeutic procedures. These treatments often have a sequential staging of treatment components that are designed to build upon one another until the therapeutic goals are reached. Because of their structure, therapists using these treatments are more likely to stay focused on the larger goals of treatment and not get sidetracked by the inevitable daily problems and "crises" that often arise with this client population.

Empirically supported treatments usually emphasize skill building to manage emotional distress and behavioral disturbance. Children are taught specific skills for self-regulation of their

thinking, affect, and behavior. Parents are taught skills for managing children. Treatment components often are variations of basic cognitive-behavioral techniques, and usually include didactic procedures such as psychoeducation, expressive procedures such as exposure therapy, cognitive procedures such as cognitive restructuring, and child behavior management techniques. These procedures are designed to teach and build skills to manage the targeted problems.

Empirically supported treatments typically use techniques involving repetitive practice of skills with therapist feedback. Practice occurs both within treatment sessions and between sessions in the home, school, or community. The use of role-plays and homework is common in these therapies. These learning strategies maximize the likelihood that newly acquired skills will generalize to every day life.

For children, there are several key skills that are common among empirically supported treatments within child mental health, and are also components many of the supported treatments described above. These elements include: (1) skills for emotion identification, processing, and regulation, (2) anxiety management skills, (3) skills for the identification and alteration of maladaptive cognitions, and (4) problem solving skills. All of these skills are applicable to reducing the most common problems that may be the direct impact of abuse. However, they also are useful in addressing the additional problems and difficulties that many abused children have. These general skills cut across the treatment of a variety of emotional and behavioral disorders and can be considered basic and fundamental treatment components. Therefore, clinicians working with abused children should be knowledgeable and skilled in the use of these procedures.

When dealing with children, especially if they have concerning abuse related behavioral reactions or externalizing behavior problems, it is necessary to include treatment components that address the child's environment. For most children, this means working closely with their parents or caregivers and their larger family system. The general principle of treatment for parent-child relationships is to promote positive interactions between parents and children while reducing negative interactions. This goal is accomplished through several approaches. Parents are taught to use effective behavior management skills based upon reinforcement of positive behavior, rather than relying primarily on punishment of negative behavior. Parents are taught the importance of consistency and follow through as essential ingredients for changing child behavior. They are taught (1) skills to reward and reinforce all manifestations of positive behavior, (2) how to strategically ignore minor or irritating behavioral problems, (3) how to give effective instructions, and (4) how to implement nonviolent consequences such as time-out or the removal of privileges. Parents are also taught how to recognize and avoid the development of negative interactions with their children, and techniques for constructing positive experiences and increasing their frequency.

As can be seen for the treatment descriptions presented above, nearly all of the empirically supported treatments contain some form of these therapeutic elements. They are goal-directed, structured in their approach, and teach appropriate skills to children and parents. Therefore, even when confronted with complex situations of abuse, practitioners can begin with this core set of approaches and adapt and add to them as necessary.

General Principles of Treatment

While each case of intrafamilial child abuse presents unique challenges, current scientific knowledge about the effects of child abuse and the efficacy of intervention suggests several general principles of treatment that can be applied to most cases. They are based upon the relevant scientific literature, and findings from the field's years of clinical experience treating abused children. Like any guidelines, these principles are not meant to be followed lockstep in every case. Rather, they offer direction and basic precepts that can be used to guide treatment planning.

1. Children's abuse experiences should be acknowledged and characterized as wrong, unlawful, and harmful in all abuse-specific interventions with children, families, and parents. Child abuse is never acceptable or warranted. Offending parents often have a rationale for their abusive behavior that is based upon distorted ideas of child welfare. Interventions should guard against being co-opted by these rationales.

2. Children's physical and emotional safety should be assessed and given significant weight in treatment planning and the interventions undertaken. It is unlikely that any child can be placed in an absolutely safe environment. However, a reasonable and acceptable level of safety should be established in the child's environment prior to treatment for problems related to abuse. It is unlikely that children continuing to live in situations that they consider to be dangerous or threatening can be treated successfully. Safety should be maintained throughout course of treatment, and should be a criteria for discharge from treatment.

3. Systematic clinical assessments of children and parents for both abuse-related and general mental health and behavioral problems should be conducted prior to initiating therapy. Results of systematic clinical assessments should form the basis for all treatment plans.

4. Systematic clinical assessment should include a comprehensive examination of the child's lifetime victimization and trauma history. Such an examination is <u>not</u> a forensic evaluation conducted to gather evidence for legal purposes. Rather, it is a clinical examination designed to assess the child's relevant history, and identify problems that will be the targets of treatment.

5. Systematic clinical reassessment of children and parents should be conducted at periodic intervals to determine treatment progress and provide information on which to base revisions to treatment plans and treatment focus.

6. Interventions should be selected and matched to the problems, disorders, and conditions identified in the systematic assessments of abused children and their parents.

7. Treatment protocols with the highest levels of empirical and clinical support for their effectiveness with the specific problems identified in the assessment process should be used as the first choice interventions for abused children and their parents.

8. Therapy is not a risk-free endeavor. Clinicians should be aware of potential harmful effects of therapy and assess the potential risks of any treatment. The potential benefits of a treatment should be balanced against its risks in the treatment selection process. Treatments with higher than average levels of risk should not be used unless there is convincing evidence that children will benefit greatly.

9. Interventions with abused children should be abuse-informed. That is, interventions should explicitly and directly address the abuse incidents experienced by the child, and the consequent emotions, cognitions, and behaviors exhibited by the child as a result of the abuse. The child's maladaptive behaviors, thoughts, and feelings related to the abuse they experienced should be the primary targets of intervention.

10. Children should not be in treatment specifically for abuse-related problems unless the treating clinician agrees that the child has a history of abuse.

11. Treatment of the abuse-related problems of the child should be the central, organizing focus of treatment, regardless of treatment modality (e.g., individual, group, parent-child, or family therapy) or the participants in treatment (e.g., abused child, nonabused siblings, parents, or extended family).

12. In most cases, the term of treatment for the abused child will be short to moderate (i.e., 12-24 sessions). However, this presumption depends on the presenting problems assessed. Individual client differences will affect treatment duration, and a minority of abused children will require more extended treatment.

13. Treatment should be conducted in the least restrictive environment with the least amount of burden on the family.

14. The ultimate, long-term functioning and welfare of the abused child should be the guiding principle of all treatment, regardless of modality or participants.

15. Treatment should have as a goal the prevention of future problems often associated with a history of abuse (e.g., substance abuse, delinquency, revictimization), as well as relief of the current problems experienced by the child.

16. Parental acknowledgment of the abuse, belief of the child, and support of the child should be encouraged as part of treatment.

17. Whenever possible, supportive, non-offending parents should be included in the treatment of abused children.

18. When clinically indicated, parents should receive appropriate treatment to enhance their ability to support, care for, and effectively parent the abused child and to provide a safe environment for the child.

19. When clinically indicated, offending parents should receive appropriate treatment for their abusive behavior.

20. When possible, treatment interventions should be used to improve the quality of parent-child relationships in abusive families.

21. When clients have achieved the therapeutic goals, treatment should end.

22. If it is clear that clients are not benefitting from treatment or that treatment is being harmful, treatment should be changed or discontinued.

CONCLUSION

Physical and sexual abuse of children is a difficult social problem affecting the growth and development of a substantial proportion of American youth. Abused children are at significantly increased risk for suffering a variety of medical, emotional, behavioral, relational and social problems that can affect them lifelong. Mental health intervention with child victims and their families can help ameliorate current problems and reduce the risk of the development of future ones. However, this beneficial effect can occur only if effective interventions are developed, tested, and most important, actually used with child victims of abuse and their families. Therefore, practitioners in the field need ready access to information describing interventions that are likely to help their clients, and they need training in the proper use of these treatments. The goal of these Guidelines was to provide practitioners with some tools for judging the utility of treatment protocols, and to provide them with information and direction concerning treatments commonly used with physically and sexually abused children. Practitioners can then use this information in their treatment planning and abused children and their families will benefit. Ultimately, society at large that will benefit from better services being provided to child victims and their families.

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